

1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE EASTERN DISTRICT OF TEXAS
3 TEXARKANA DIVISION

4 THE STATE OF TEXAS

5 VS.

6 THE AMERICAN TOBACCO
7 COMPANY, ET AL

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C.A. NO. 5:96CV91

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13 DEPOSITION OF
14 CHARLES STILES, M.D.
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19

20 On July 29, 1997, the video deposition of
21 CHARLES STILES, M.D., a witness in the above-styled
22 cause, was taken at the instance of the Plaintiff in
23 the offices of Fulbright & Jaworski, 1301 McKinney,
24 Houston, Texas, pursuant to Stipulation of Counsel
25 contained herein.

COPY

Those persons present were as follows:

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51710 5922

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51710 5923

E X H I B I T S I N D E XDEPOSITION OF CHARLES STILES, M.D.

July 29, 1997

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01:04:14 1

THE REPORTER: Please state the stipulations on the record.

2

3

MR. THORPE: Eastern District Plan.

4

01:05:50 5

THE VIDEOGRAPHER: Today is the 29th day of July, 1997. It's five minutes after 1:00 o'clock; and we are on the record.

6

7

8

9

10

CHARLES M. STILES, M.D.,

11

having been duly sworn, testified as follows,

12

to-wit:

13

14

EXAMINATION BY MR. THORPE:

01:06:12 15

Q Now, Dr. Stiles, my name is Larry Thorpe; and we have just introduced ourselves. And this is Chris Quinn, and we are two of the lawyers representing the State of Texas against the tobacco industry.

16

17

18

19

01:06:22 20

You understand that?

21

A Yes.

22

Q We have not met in the past;

23

is that correct?

24

A That's correct.

01:06:32 25

Q And have you given -- By your disclosure,

51710 5925

01:06:34 1 you have given some depositions prior to this; is
2 that correct?

3 A Yes.

4 Q So, you know the process. You are under
01:06:42 5 oath, and all of the things that you say today will
6 be taken or can be used as testimony at the time of
7 trial. And I say that only for if you don't
8 understand a question that I ask you, please ask me
9 to rephrase it or change it so that at the end of
01:07:00 10 the day my questions and your answers will match.

11 Is that okay with you?

12 A Fine.

13 Q Okay. If at any time you need to take a
14 break during this deposition for any reason, please
01:07:14 15 let me know; and I will be happy to accommodate
16 you.

17 A I would probably like to take a break
18 about every hour.

19 Q Okay. If somebody will keep track, that
01:07:24 20 will be fine.

21 MR. BORMAN: I'll keep track.

22 Q We were told earlier that there is a time
23 constraint. You have to leave at 5:00; is that
24 correct?

01:07:34 25 A 5:30.

51710 5926

01:07:40 1 Q At 5:30? If we are not able to finish at
2 that time, we will probably ask to have a second day
3 of depositions; and we will arrange that later.

4 A I understand.

01:07:48 5 Q Would you state your name for the record,
6 please.

7 A Charles Merrill Stiles.

8 Q What's your date of birth, Dr. Stiles?

9 A March 9th, 1938.

01:08:12 10 Q Do you smoke?

11 A I do not.

12 Q Have you ever smoked?

13 A No.

14 Q What's your residential address?

01:08:38 15 A : [DELETED]

16 Q And the telephone number there?

17 A : [DELETED]

18 Q Do you also have a professional address?

19 A No. That is my professional address.

01:09:00 20 Q So, this is both your residence and your
21 professional?

22 A Yes.

23 Q Dr. Stiles, we were provided in the
24 disclosure -- Among the documents we were provided
01:09:20 25 in disclosure was a curriculum vitae. (Tendering)

51710 5927

01:09:22 1 Could you look at this ---

2 A Surely.

3 Q --- and tell me if there have been any
4 changes since the time that this was presented to
01:09:28 5 us?

6 A (Reviewing) I'm no longer a member of the
7 Texas Academy of American College of Physicians or
8 an affiliate of the American College of
9 Cardiology ---

10 Q Okay.

11 A --- nor the Texas Academy of Internal
12 Medicine.

13 Q Did these changes occur after the time
14 that you retired from the practice of medicine?

01:10:10 15 A Yes.

16 Q Doctor, it says in your curriculum vitae
17 that you retired from - I assume from the practice
18 of medicine in 1992; is that correct?

19 A Yes.

01:10:44 20 Q What was the reason for your retirement?

21 A It was my choice.

22 Q And prior to your retirement, your vitae
23 reflects that you worked at Doctors Clinic from 1970
24 until 1992; is that correct?

01:11:02 25 A Yes.

51710 5928

01:11:06 1 Q Could you tell us what Doctors Clinic is
2 that -- You have here that there were offices in
3 Galveston, Texas City, and Friendswood. Was this a
4 clinic with several offices?

01:11:18 5 A Yes.

6 Q Which was the main office where your
7 office or your professional office was housed?

8 A The Texas City office.

9 Q What was the address there?

01:11:36 10 A I don't remember.

11 Q Does the Doctors Clinic still exist in
12 Texas City?

13 A The building is still there. I understand
14 that at least as of some months ago, that at least
01:11:52 15 one of the former physicians was still practicing
16 out of at least part of the building. But that's
17 really all I know about. I know that the group no
18 longer exists.

19 Q Did you own the practice - the Doctors
01:12:12 20 Clinic practice?

21 A The practice was owned by Doctors Clinic.

22 Q And this was incorporated or a PA?

23 A PA. Well, the Doctors Clinic was
24 incorporated. I was PA.

01:12:34 25 Q How many physicians practiced there?

51710 5929

01:12:38 1 A It varied over the years from five or six
2 up to nine or ten. At the time I left, there were
3 four or five.

4 Q Were there multiple specialties at this
01:12:48 5 clinic?

6 A Yes.

7 Q Were they all internal medicine, or what
8 areas were covered?

9 A Internal medicine, cardiology,
01:13:04 10 cardiovascular, and pulmonary. In the more distance
11 past, there had been an oncologist.

12 Q And these physicians also staffed the
13 other offices in Galveston and Friendswood?

14 A Not every physician went to every office.

01:13:26 15 Q You staffed all three?

16 A There was a time period when I did.

17 Q Where was the office in Galveston?

18 A 1501 Broadway for many years; and then in
19 later years it was in a shopping mall area. The
01:13:48 20 address, I don't recall.

21 Q Did you have set hours at each of these
22 clinics?

23 A For the most part, yes.

24 Q And you rotated through these different
01:14:04 25 areas on different days?

51710 5930

01:14:04 1 A Yes.

2 Q Dr. Stiles, are you currently employed?

3 A I'm self-employed.

4 Q And what do you do currently?

01:14:34 5 A Consulting work.

6 Q Could you explain a little bit more about

7 what you mean by "consulting work"?

8 A I render services primarily for law firms.

9 Q Which law firms?

01:15:04 10 A A number of different law firms.

11 Q Who are you currently consulting for -

12 which firms other than Shook, Hardy?

13 A At this moment, I'm not consulting with

14 any other law firm.

01:15:20 15 Q In the past two years?

16 A A number of firms, none of which have

17 anything to do with this litigation.

18 Q What areas do you consult in for these law

19 firms?

01:15:34 20 A Primarily internal medicine and

21 geriatrics.

22 Q Do you review charts for these law firms?

23 A In some instances, yes.

24 Q What other areas do you consult in?

01:15:58 25 A There are times when they ask just for an

01:15:58 1 opinion.

2 Q Opinion based on your review of medical
3 records?

4 A Usually.

01:16:14 5 Q Are you also asked to testify for these
6 different firms?

7 A On occasion.

8 Q In the last two years, how many times have
9 you been asked to consult by these various law
01:16:42 10 firms?

11 A I cannot really answer that question.
12 Perhaps eight or ten times, maybe less than six. I
13 just -- I really don't have a number for that, but
14 in that ball park.

01:17:00 15 Q These firms that you work for, do you work
16 primarily for defense firms?

17 A Both.

18 Q About approximately what percentage for
19 defense and what permission for plaintiffs?

01:17:16 20 A The majority of my time is for defense
21 firms.

22 Q Greater than 50 percent?

23 A Yes.

24 Q Greater than 70 percent?

01:17:24 25 A Yes.

51710 5932

01:17:26 1 Q Greater than 90 percent?
2 A Probably not.
3 Q So, between 80 and 90 percent?
4 A Something like that, yes.
01:17:38 5 Q How much do you charge per hour?
6 A \$500.
7 Q And is this depending on the type of work
8 or straight 500?
9 A No. It depends on the type of work.
01:17:54 10 Q How much do you charge for deposition
11 testimony?
12 A I charge the same type of charge for
13 deposition and trial testimony and for preparation
14 of cases such as this.
01:18:08 15 Q And that's the \$500?
16 A Yes.
17 Q Are there instances where you also --
18 Excuse me. Strike that.
19 Are there instances where you also charge
01:18:18 20 more?
21 A No.
22 Q Do you also get paid for travel ---
23 A Yes.
24 Q --- and incidentals?
01:18:24 25 A Yes. Yes.

51710 5933

01:18:34 1 Q How long have you been consulting with law
2 firms in the legal industry?

3 A I did some consulting prior to retirement,
4 maybe half a dozen times or less.

01:19:00 5 Q And you have done it full-time since your
6 retirement?

7 A I don't work full-time.

8 Q In terms of your consulting, that's the
9 only thing you do now? You don't practice?

01:19:12 10 A I don't practice any clinical medicine. I
11 do some consulting for a firm. In that capacity I
12 occasionally will see a patient, not as a
13 doctor-patient, but as an examining physician.

14 Q So, as doing IME's?

01:19:32 15 A Exactly.

16 Q And this is for law firms?

17 A No. This is for -- I don't know how to
18 classify actually the firm. I don't know that much
19 about the firm except that I'm employed to perform
01:19:50 20 that service. And their clients are primarily

21 insurance carriers, Texas Workmen's Compensation,
22 that type of area.

23 Q What's the firm or the company that you
24 work for that you do the IME's?

01:20:04 25 A It doesn't have anything to do with this

51710 5934

01:20:06 1

litigation.

2

Q I'm still entitled to know what the name
of that firm is.

4

A I'll decline to answer.

01:20:20 5

MR. BORMAN: Dr. Stiles

6

apparently feels there are some

7

confidentiality issues that he is

8

concerned about.

9

Q Is this information privileged in any way?

01:20:34 10

A I just don't see the relationship between
the name of that firm and the possible conflict of
confidentiality and the purpose for which we are
here today.

14

Q Are you employed to do these IME's by this
firm?

01:20:42 15

16

A Yes.

17

Q And you do this for the insurance industry
or for whomever?

19

A I only do it for the firm.

01:20:54 20

Q And you generate reports; is that correct?

21

A That's correct.

22

Q And these reports are then sent to Texas
Worker's Comp?

24

A In some instances, yes.

01:21:04 25

Q And are those reports privileged?

51710 5935

01:21:04 1 A I do not know.

2 Q Can you tell us why you do not want to
3 disclose the name of this firm?

4 A Because of possible conflicts in relative
01:21:18 5 confidentiality. That's all.

6 Q Dr. Stiles, when you were still practicing
7 medicine at Doctors Clinic, what type of practice
8 did you have?

9 A Internal medicine; and a large portion of
01:21:58 10 that was geriatric medicine, as that is a part of
11 internal medicine. It also was weighted toward
12 cardiovascular disease.

13 Q You trained in cardiovascular disease?

14 A Yes.

01:22:22 15 Q Was your internal medicine practice more
16 general medicine or was it straight internal
17 medicine?

18 A I don't understand the difference of those
19 two terms.

01:22:36 20 Q In a lot of practicing or private
21 practice, internal medicine doctors do more of a
22 general medicine. So, you looked at all specialties
23 or all disease processes rather than just narrowing
24 only to cardiovascular or only to geriatrics; is
01:22:52 25 that correct?

51710 5936

01:22:54 1 A That's correct.

2 Q And in the last ten years of your practice

3 or let's say from 1980 until you retired, what

4 percentage of your practice involved the treatment

01:23:10 5 and care of elderly or geriatric patients?

6 A There would be no way for me to give an

7 accurate answer. The estimate would be the

8 majority. My practice was weighted toward the older

9 adult.

01:23:40 10 Q Of this elderly or older population, what

11 percentage were private-pay or insurance-covered?

12 A The majority.

13 Q What percentage of these patients were

14 Medicare patients?

01:24:14 15 A Probably close to 50 percent. I don't

16 really know the answer to that.

17 Q And in your earlier testimony when you

18 said that most of them were private-pay, you also

19 included those that were paid by Medicare; is that

01:24:30 20 correct?

21 A Right. And you said private-pay or

22 insurance, and I included Medicare as part of the

23 insurance.

24 Q Do you know what percentage were

01:24:44 25 non-Medicare type of pays? When I refer to

51710 5937

01:24:48 1 insurance, I'm talking about private or pension-type
2 insurance.

3 A Uh-huh.

4 MR. BORMAN: Mr. Thorpe, are you
01:24:54 5 now talking about just the geriatric
6 population?

7 MR. THORPE: Just his geriatric
8 population.

9 A Okay. I was having trouble. I would say
01:25:06 10 the majority of the geriatric age group were
11 Medicare patients. There were some who would be
12 Medicaid patients, but I don't -- I don't have a way
13 of accurately separating those, but they would
14 definitely be both types.

15

16 (By Mr. Thorpe)

17 Q That was my next question. Do you know
18 what percentage were Medicaid patients?

19 A I really don't.

01:25:28 20 Q Did the Medicare-Medicaid group make the
21 largest proportion of your, quote, elderly or
22 geriatric population?

23 A You mean combined or people who were ---

24 Q Combined.

01:25:46 25 A Combined. Not those who were covered by

51710 5938

01:25:46 1 one or the other?

2 Q No.

3 A Yes, I would say that the combined
4 Medicare plus the Medicaid population would have

01:26:00 5 constituted probably more than 50 percent of the
6 patients that I saw.

7 Q And the other group?

8 A Would be younger than Medicare age.

9 Q And you don't know how many -- what the
01:26:16 10 percentage of Medicare versus Medicaid patients?

11 A I really don't.

12 Q Medicare, 50 percent or more?

13 A There were more Medicare patients than
14 Medicaid patients, yes.

01:26:38 15 Q How much does Medicare reimburse you on
16 average for office visits?

17 A I don't know. Towards the end it varied
18 according to the type of visit. And it was a fairly
19 complex system, which I really don't remember the
01:26:58 20 details of that.

21 Q Did someone in your office take care of
22 those details?

23 A Yes.

24 Q The same question with regard to Medicaid
01:27:10 25 reimbursement. How much did Medicaid reimburse you

51710 5939

01:27:10 1 on the average?

2 A I really don't now.

3 Q Was this something that you let your

4 office manager and accountants deal with?

01:27:18 5 A Yes.

6 Q And it's not something you have studied in

7 the past so that you were familiar with?

8 A No.

9 Q What states have you had or held medical

01:27:30 10 licenses in?

11 A Texas and Kansas.

12 Q Do you still have current licenses in both

13 states?

14 A The -- I've not practiced in decades in

01:27:48 15 Kansas. The way I understand it is that you are

16 still licensed; but if you are going to practice,

17 you have to take another step now. And I have not

18 taken that new step.

19 Q Your Kansas license was because of where

01:28:00 20 you trained?

21 A Yes.

22 Q And it was inactive -- Did you ever

23 practice in Kansas?

24 A During my period of training, but not in

01:28:10 25 private practice, no, I did not.

51710 5940

01:28:12 1 Q When were you licensed in Texas?
2 A 1970.
3 Q The same time you began practicing at
4 Doctors Clinic?
01:28:22 5 A Yes.
6 Q Have either of your licenses ever been
7 suspended or revoked?
8 A No.
9 Q Your resume' states that you went to
01:28:48 10 medical school at the University of Kansas; is that
11 correct?
12 A Yes.
13 Q And you received your M.D. when?
14 A That would have been 1964.
01:29:10 15 Q Where did you do your postgraduate
16 training?
17 A It was all done at the Kansas University
18 Medical Center - the internship, two years of
19 fellowship, a year of cardiology.
01:29:34 20 Q At that time was the cardiology fellowship
21 only one year?
22 A There was the possibility of taking a
23 second year. That was the time of the Vietnam War,
24 and I was a part of a program that only permitted
01:29:54 25 completion of the one year. After that, I spent two

51710 5941

01:29:54 1 years in the Air Force.

2 Q Your deferral period was over after your

3 residency?

4 A Exactly.

01:30:08 5 Q When did you move to Texas?

6 A 1970.

7 Q Why did you choose South Texas -

8 Galveston?

9 A I was looking for a job and the people in

01:30:24 10 Galveston were looking for an employee and we just

11 happened to find each other.

12 Q Aside from your one year in cardiology,

13 have you done any formal fellowships since that

14 time?

01:30:38 15 A No.

16 Q Are you board certified in internal

17 medicine?

18 A Yes.

19 Q Have you ever had any formal postgraduate

01:31:24 20 training in geriatrics or gerontology?

21 A If you mean by "formal," did I take a

22 fellowship in geriatrics, the answer is no. I did

23 take several fairly intensive training courses in

24 preparation for taking the boards in geriatric

01:31:44 25 medicine.

51710 5942

01:31:46 1 Q These are CME courses?
2 A Yes.
3 Q And this was for preparations for the
4 boards?
01:31:50 5 A Yes.
6 Q But not in actual training in geriatric
7 medicine?
8 A Not in forms of a fellowship.
9 Q Dr. Stiles, in what professional societies
01:32:16 10 are you still a member? And I'll go back and ask
11 you about memberships while you were still
12 practicing - but your current memberships in medical
13 societies.
14 A The American Medical Association, the
01:32:28 15 Texas Medical Association, the Galveston County
16 Medical Society. Once you're a member, you're
17 always a member of Phi Beta Kappa and Alpha Omega
18 Alpha.
19 Q But in terms of professional societies,
01:32:46 20 rather than honorary societies, you are currently
21 with A.M.A., T.M.A., and the Galveston County?
22 A That's correct.
23 Q Are you also a member of the Houston
24 Medical Society?
01:32:54 25 A No.

51710 5943

01:33:02 1 Q When you were still practicing medicine,
2 there are a number of other societies that you have
3 listed on your resume'. In what other societies
4 were you a member?

01:33:16 5 A The primary one would have been the
6 American College of Cardiology, which I was a member
7 of from about 1970 on until the time that I
8 retired.

9 There was a time when I was a member of
01:33:34 10 the Texas Society of Internal Medicine. There was
11 the American Society of Angiology. At one time I
12 was a member of that.

13 Q Were you also a member of the American
14 College of Internal Medicine or the American College
15 of Physicians?

16 A No, I was not.

17 Q When did you drop your affiliation with
18 the American College of Cardiology?

19 A Sometime around the time that I retired.

01:34:24 20 Q Dr. Stiles, do you know whether or not the
21 A.M.A. and the T.M.A. and the American College of
22 Cardiology have position papers or position
23 statements on tobacco?

24 A I suspect they do.

01:34:38 25 Q Have you ever seen any of these?

51710 5944

01:34:44 1 A I can't say that I -- If I have, I don't
2 recall them.

3 Q So, you have no personal knowledge about
4 the position papers that have been published by
01:34:58 5 these entities?

6 A I'm not familiar with their contents, no.

7 Q Each of these entities have published
8 position papers about and concerning the hazards of
9 tobacco and the hazards of smoking. And you have
01:35:34 10 not seen any of these; is that correct?

11 A It's possible that if they were part of,
12 for example, the JOURNAL OF THE AMERICAN MEDICAL
13 SOCIETY, I subscribe to that. So, if it was a part
14 or included as a part of the Journal at some point,
01:35:50 15 it's very likely that I saw it at that time. But
16 other than that, I'm not familiar with seeing it as
17 a separate document.

18 Q Have you ever voiced any written or verbal
19 disagreement with any of the policies that you know
01:36:02 20 of?

21 A Since I cannot quote what their policies
22 are, it would be hard for me to say whether I agreed
23 or disagreed.

24 Q I will come back.

01:36:18 25 Dr. Stiles, when you were practicing

51710 5945

01:36:24 1 medicine, did you keep any medical textbooks that
2 you used as references?
3 A Yes.
4 Q Could you name the textbooks that you felt
01:36:36 5 were authoritative in cardiology or cardiovascular
6 disease?
7 A I wouldn't consider any texts to bear the
8 term "authoritative." They are useful and helpful
9 and informative, but I wouldn't classify them as
01:36:50 10 authoritative.
11 Q Why is that, Doctor?
12 A Because they are outdated by the time they
13 come off the press and there are opinions expressed
14 by many different authors and I might agree with
01:37:04 15 some of the things that are said and I might not
16 agree with everything that was said.
17 Q Which of the cardiology or cardiovascular
18 texts do you keep as reference books?
19 A I'm trying to remember which ones I kept
01:37:18 20 because I sent a number of books to my son when I
21 retired. So, I'm not ...
22 Hurst is one that comes to mind.
23 Q Could you spell that?
24 A H-u-r-s-t.
01:37:28 25 Q And that's TEXTBOOK OF CARDIOLOGY?

51710 5946

01:37:32 1 A I'm not sure of the exact title, but it is
2 a text on cardiology.

3 I had a number of texts on
4 echocardiography because I was particularly
01:37:46 5 interested in that, and I can't recall the authors
6 right now.

7 Q Could you tell us what echocardiology is?

8 A It's the sound wave study of the motion of
9 the heart.

01:37:56 10 Q And this is a procedure that you use to
11 diagnose cardiovascular disease or diseases of the
12 heart; is that correct?

13 A Yes.

14 Q Did you keep any reference books on
01:38:12 15 pulmonology?

16 A Yes. I don't recall their authors.

17 Q How about oncology?

18 A Yes. I don't recall the author.

19 Q Did you also have texts that you used as
01:38:50 20 references in geriatrics and gerontology?

21 A Yes.

22 Q What were the names of those books?

23 A I don't recall.

24 Q Are you familiar with THE PRINCIPLES OF
25 GERIATRIC MEDICINE AND GERONTOLOGY?

51710 5947

01:39:00 1 A That rings a bell, yes.

2 Q Was that one of the books that you might

3 have had?

4 A I might -- That might be one of them.

01:39:24 5 Q During the time that you practiced

6 medicine and practiced internal medicine, did you

7 have occasions to use these books as references to

8 some - for some medical problem that you might have

9 seen?

01:39:36 10 A Yes.

11 Q Was that something you did frequently?

12 A On occasion.

13 Q Using textbooks as references, is this

14 something that most doctors do in their practice?

01:39:58 15 A I can't really speak for most doctors.

16 It's something that I did, and I assume most doctors

17 do that. But that is an assumption.

18 Q And that would be a prudent thing to do

19 for a physician practicing medicine given ---

01:40:10 20 A I would think so.

21 Q --- the broad amount of knowledge?

22 A (Witness nods head affirmatively)

23 Q When you were practicing medicine --

24 Strike that.

01:40:20 25 Currently do you still subscribe to any

51710 5948

01:40:22 1 medical journals?

2 A Yes.

3 Q What journals?

4 A THE JOURNAL OF THE AMERICAN MEDICAL

01:40:28 5 ASSOCIATION, THE NEW ENGLAND JOURNAL OF MEDICINE,
6 THE ANNALS OF INTERNAL MEDICINE, MEDICAL CLINICS OF
7 NORTH AMERICA MEDICAL LETTER. There may be others.
8 That's all I can recall right now.

9 Q Do you subscribe to any journals that are
01:40:48 10 specific to geriatric medicine?

11 A No, I do not.

12 Q When you were practicing medicine, were
13 there other journals that you subscribed to?

14 A Yes.

01:41:02 15 Q Could you name those?

16 A THE AMERICAN JOURNAL OF CARDIOLOGY, THE
17 ARCHIVES OF INTERNAL MEDICINE. There was a
18 geriatric journal, the exact name I don't recall. I
19 believe it was GERIATRICS, but it may have been some
01:41:36 20 variation of that. AMERICAN JOURNAL OF MEDICINE,
21 those are the ones that come to mind. There may
22 have been others.

23 Q Were you a member of the American Society
24 of Geriatrics?

01:41:44 25 A No.

51710 5949

01:41:48 1 Q Are you familiar with their journal?
2 A I probably have read articles from it, but
3 I have never taken their journal.
4 Q The journals that you have related to us
01:42:06 5 and magazines - did you read them frequently?
6 A Yes.
7 Q Are articles in these type of peer-review
8 journals important for a physician to keep abreast
9 of ongoing medical advancements?
01:42:30 10 A Journal articles are useful and helpful
11 and informative, yes.
12 Q So, it's important to keep abreast of
13 current things that are published in that
14 literature; is that correct?
01:42:48 15 A That's one way of keeping abreast, yes.
16 Q And other ways are to go to symposia; is
17 that correct?
18 A Yes.
19 Q What other ways did you keep abreast of
01:43:02 20 ongoing medical events?
21 A Discussions with colleagues.
22 Q Were there any meetings - scientific or
23 medical meetings that you regularly attended while
24 you were practicing medicine?
01:43:28 25 A I attended a number of meetings of the

51710 5950

01:43:34 1 American College of Cardiology. In terms of
2 numbers, I'd say that would be the one that I
3 attended in terms of most frequently.

4 Q Doctor, do you feel it's important in
01:43:48 5 studies that are reported in the medical literature
6 to report not only positive findings, but negative
7 findings?

8 A I'm not sure what you mean exactly by
9 negative and positive findings.

01:44:08 10 Q There are -- Usually a research project is
11 undertaken to answer some question. And sometimes
12 the answer is not favorable to the position of the
13 researcher; is that correct?

14 A Well, I think in most instances the
01:44:26 15 researcher is setting out to answer a question and
16 doesn't necessarily have in mind what he's going to
17 consider favorable and unfavorable.

18 Q Well, maybe I kind of poorly stated the
19 question. In terms of the result -- The medical
01:44:46 20 literature is oftentimes the results of studies that
21 are done by a group of physicians or researchers; is
22 that correct?

23 A Yes.

24 Q And the information that is published are
01:44:56 25 the findings of these studies, correct?

51710 5951

01:44:58 1 A Yes.

2 Q And my question is: Is it important for
3 these researchers to publish and discuss whatever
4 findings they have as a result of these studies?

01:45:16 5 A Yes, without a connotation, as you made
6 reference to earlier, as to whether they are, quote,
7 favorable or unfavorable - just to publish what they
8 found - if that is your question, the answer is yes.

9 Q And it's important for in these
01:45:34 10 publications to include the findings that they made
11 in these studies - all of the findings; is that
12 correct?

13 A Yes.

14 Q And not to publish just those findings
01:45:50 15 that they want to publish?

16 A That would be dishonest.

17 Q Dr. Stiles, when you were practicing in
18 the Galveston area, did you hold any academic
19 appointments during that period of time?

01:46:38 20 A Yes.

21 Q Was that at The University of Texas
22 Medical Branch?

23 A Yes.

24 Q In the Department of Internal Medicine?

01:46:44 25 A Yes.

51710 5952

01:46:46 1 Q Was this a full-time appointment or an
2 adjunct appointment?
3 A It was not full-time.
4 Q So, it was an adjunct appointment?
01:46:56 5 A That was not the term that was used. I
6 was an instructor, and I taught part-time.
7 Q I think back then it was called clinical
8 instructor?
9 A That is correct.
01:47:10 10 Q What years were you a clinical instructor
11 at UTMB?
12 A I'm still on the staff.
13 Q During your training or subsequent when
14 you were in practice, did you participate or conduct
01:47:34 15 any research projects?
16 A I'm sorry. Did you say during my
17 training?
18 Q Training or subsequent when you were in
19 private practice, did you participate in or conduct
01:47:44 20 any research projects?
21 A Not in my private practice. As a student
22 I did some what we called rotations, which would be
23 a period of months participating in research that
24 was primarily being carried on by staff members.
01:48:04 25 Q Was this when you were a resident or a

51710 5953

01:48:04 1 student?

2 A A student.

3 Q A medical student?

4 A Yes.

01:48:12 5 Q What area of research were you involved

6 in?

7 A One was a study of the usefulness of

8 tracheostomies - tracheotomies.

9 Q And the other?

01:48:34 10 A The other? It's been a long time ago. I

11 don't remember.

12 Q Were either of these studies involved with

13 any diseases that have been linked to smoking?

14 A No.

01:48:54 15 Q So, you were more a pair of hands than

16 anything during that period?

17 A During the time we liked to think that we

18 were more than that; but I'm sure from the staff's

19 standpoint, we were a pair of hands.

01:49:08 20 Q I understand.

21 As a clinical instructor at UTMB, it also

22 says that you were at St. Mary's when St. Mary's

23 still existed. Were you involved in teaching

24 residents and medical students?

01:49:28 25 A Primarily medical students. We had some

51710 5954

01:49:32 1 association with the interns and residents, but my
2 role as a clinical instructor was primarily with the
3 students.

4 Q Was teaching that you did confined to
01:49:50 5 clinical rounds, or did you also do some didactic
6 teaching?

7 A It was 80 percent making rounds and then -
8 that's an estimate - and then as a part of that,
9 there might be some didactic teaching, not so much
01:50:06 10 in a formal classroom setting, but as around a table
11 with a group of students after the rounding had been
12 completed.

13 Q The medical student, the conference in the
14 nursing station area?

01:50:18 15 A Well, we were able to usually have a room.

16 Q What were the areas that you were
17 primarily responsible in terms of teaching?

18 A It would cover the broad field of internal
19 medicine. It would be related to whatever
01:50:38 20 particular patients we had seen that day or
21 particular disease entities that one of the students
22 was primarily interested in.

23 Q During your period of time that you taught
24 medical students, did you -- Strike that.

01:51:00 25 In the period that you were teaching

51710 5955

01:51:04 1 medical students, were there occasions where you
2 discussed the hazards of smoking with this
3 relationship, the disease processes?

4 A I can't recall a specific such instance,
01:51:24 5 but I suspect that we discussed smoking and the fact
6 that it was a risk factor for the development of
7 certain disease processes.

8 Q And this would be really kind of dependent
9 on the particular patient population and what you
01:51:52 10 were discussing; is that correct?

11 A Well, I don't know that I would discuss
12 the word "patient population" because we would see
13 all types of patients. But it could be dependent
14 upon who we might have seen on a particular day. We
01:52:08 15 might see several patients, and one might be
16 selected for then a discussion at greater length.

17 Q And this would be the time when you would
18 bring up risk factors such as smoking, correct?

19 A Yes.

01:52:24 20 Q Dr. Stiles, have you ever taken a formal
21 course in epidemiology?

22 A In medical school.

23 Q Could you tell us or define what the study
24 of epidemiology concerns?

01:52:48 25 A It's a study of usually a defined

51710 5956

01:52:54 1 population and examining in that population the
2 presence or absence of certain factors or diseases
3 which may be of interest in that particular study.

4 Q And epidemiology is intimately involved in
01:53:10 5 the study of factors that result in disease; is that
6 correct?

7 A That could a part of an epidemiology
8 study, yes.

9 Q Are epidemiologic studies important in
01:53:24 10 establishing causal links to various disease
11 processes?

12 A I don't think you can establish from an
13 epidemiology study a cause and effect. You can look
14 at what occurs in a population, see what factors are
01:53:38 15 in that population; but to say that an epidemiology
16 study is the way to or is even designed to address
17 the issue of cause, I don't believe that's the real
18 purpose of an epidemiology study.

19 Q But in many of these studies the results
01:54:02 20 oftentimes show a strong inference or probability
21 that certain risk factors are involved in disease
22 processes; is that correct?

23 A Well, an epidemiology study - we are
24 talking in generalities - would be to look to see if
01:54:18 25 there was an association between a condition and a

51710 5957

01:54:22 1 disease process. They might find a positive or a
2 negative relationship.

3 Q But that's the goal of the studies?

4 A In general, yes.

01:54:32 5 Q Okay. We have talked a couple of times
6 about or used the phrase "risk factor." Could you
7 tell us what a risk factor is as it pertains to
8 disease causation or disease processes?

9 A Again, I couldn't relate it to causation;
01:54:58 10 but I could relate it to if there are certain
11 habits, for example, that we classify or conditions
12 that we classify as risk factors. And the medical
13 connotation of that is that if an individual has a
14 risk factor, one or more, that has been shown to
01:55:28 15 give them a greater risk for the development of some
16 disease process, then that risk factor is a risk for
17 that person or that group of people to develop the
18 particular disease process in question as what we
19 mean by the term "risk factor."

01:55:44 20 Q And these risk factors -- Isn't it true
21 that these risk factors can function by themselves
22 or can be additive or synergistic with other risk
23 factors in the development of some type of disease?

24 A There are disorders in which it is
01:56:02 25 recognized that there are more than one risk factor,

51710 5958

01:56:02 1 yes.

2 Q Is smoking considered a risk factor in
3 many disease processes?

4 A "Many" is a term that has many meanings.

01:56:16 5 More than one, yes.

6 MR. THORPE: Do you want to take
7 a break now?

8 MR. BORMAN: If that's
9 convenient, it's about five minutes
01:56:24 10 until 2:00.

11 MR. THORPE: I think it's
12 convenient, yes.

13 THE VIDEOGRAPHER: It's five
14 minutes after 1:00 o'clock. We are
01:56:32 15 going off the record.

16

17 (A BRIEF RECESS WAS TAKEN.)

18

19

02:05:04 20 THE VIDEOGRAPHER: It's four
21 minutes after 2:00 o'clock. We are
back on the record.

22 (By Mr. Thorpe)

23 Q Dr. Stiles, we are back after a break.

24 Something I wrote down, but I forgot to ask you:

02:05:18 25 You say that you are still on the staff as a

51710 5959

02:05:20 1 clinical instructor at UTMB?

2 A Yes.

3 Q When was the last time that you rounded

4 with students?

02:05:26 5 A It's been several years.

6 Q Do you currently do any active

7 participation as an active instructor?

8 A No.

9 Q Has it been since the time that you

02:05:42 10 retired from practice?

11 A Prior to that.

12 Q About what year did you quit being active?

13 A I don't remember. Maybe in the Eighties.

14 I really just don't remember, but that would be

02:05:58 15 approximately that.

16 Q But prior to the time you retired?

17 A Yes.

18 Q The Doctors Clinic, was that a group of

19 physicians that formed together to make a clinic; or

02:06:16 20 did somebody own the building and hire the

21 physicians that were working there?

22 A No. It was a group of physicians who

23 practiced together.

24 Q Okay. They had separate practices, but

02:06:32 25 practiced in the same building?

51710 5960

02:06:34 1 A That is correct.

2 Q Did any of those physicians own that

3 building or ---

4 A Yes.

02:06:42 5 Q Were you one of the owners?

6 A Yes.

7 Q Did you also own the buildings in

8 Galveston and Friendswood?

9 A We owned the buildings in Texas City and

02:06:52 10 in Galveston.

11 Q And leased, then, in Friendswood?

12 A Yes.

13 Q And, also, in your consulting practice -

14 in your consulting practice, do you advertise?

02:07:06 15 A No.

16 Q Do people learn about you word of mouth?

17 A Yes.

18 Q Dr. Stiles, obviously as a doctor

19 practicing internal medicine, you prescribed drugs

02:07:28 20 in the care and treatment of your patients; is that

21 correct?

22 A Yes.

23 Q In determining the efficacy of these

24 drugs, the side effects, and possibly the safety of

02:07:48 25 these drugs, how is that process determined? How is

02:07:52 1 the drug -- How are the effects of the drugs
2 determined to be safe, efficacious, and pass the
3 muster in order for a physician to use it in his
4 clinical practice?

02:08:06 5 A You are referencing now prior to the time
6 that they become generally available for us in the
7 practice of medicine to use. Is that your
8 question?

9 Q That's correct.

02:08:20 10 A I could only address that in general terms
11 since I have not been involved in that industry.
12 But in general the medicines are - some of them are
13 examined in animal models of varying kinds, both for
14 what variable effects they might produce and also
02:08:44 15 for what ill effects they might produce. And then
16 eventually they reach the stage where they are
17 administered to human beings. And, again, these
18 subjects are examined for the hoped-for beneficial
19 effects, as well as potential side effects.

02:09:06 20 Q And these are the clinical trials that we
21 all hear about in the news occasionally?

22 A Yes.

23 Q Have you ever participated in any clinical
24 trials on drugs?

02:09:12 25 A No.

51710 5962

02:09:22 1 Q So, with regard to the safety and efficacy
2 and side effects, you rely on the studies that are
3 done by others during these clinical trials?

4 A Well, I would rely on that information
02:09:36 5 before I made a determination as whether to
6 introduce that into my own prescribing habits. And
7 then I would do my own monitoring of patients on
8 whom I had chosen to use those drugs.

9 Q For approved drugs, these drugs all have
02:09:56 10 to be approved by the F.D.A., is that correct,
11 before they are used in clinical practice after
12 clinical trials?

13 A Yes. The reason I am hesitating is I had
14 a few patients who obtained drugs from other
02:10:18 15 countries and came back and announced that they were
16 taking the medication, but they were not prescribed
17 by me.

18 Q Well, I understand that; but the drugs
19 that are currently available for you to use in
02:10:32 20 clinical practice all have to be approved by the
21 F.D.A. through the F.D.A. process; is that correct?

22 A Yes.

23 Q And you rely on the F.D.A. process and
24 their approval of drugs before you will use them in
02:10:44 25 your practice?

51710 5963

02:10:46 1 A Yes.

2 Q Dr. Stiles, I would like to turn to your

3 practice over the years from 1970 to 1992. As you

4 have stated, you practice primarily internal

02:11:10 5 medicine with a significant focusing in the

6 geriatric patient population; is that correct?

7 A Yes. And as I mentioned, also, it was

8 weighted more towards cardiovascular disease than I

9 would think of the average practice of internal

02:11:22 10 medicine.

11 Q Do the elderly have or suffer from a

12 significant cardiovascular disease problem?

13 A Yes.

14 Q Doctor, when you first saw your

02:11:46 15 patients -- Strike that.

16 In the last ten years of your practice,

17 when you first saw a patient, did you - would you

18 routinely do a history and physical on these

19 patients?

02:11:58 20 A Yes.

21 Q And would you routinely take a past

22 medical history on these patients?

23 A Yes.

24 Q Did you also take a smoking history on

02:12:08 25 your patients?

51710 5964

02:12:08 1 A Yes.

2 Q Why did you do that, Doctor?

3 A As we mentioned earlier, some factors have

4 been identified as risk factors which might place an

02:12:28 5 individual at a higher risk for the development of

6 certain disorders; so, I would want to know that

7 information.

8 Q And you considered smoking as one of these

9 risk factors?

02:12:40 10 A Smoking is a risk factor for the

11 development of certain diseases, yes.

12 Q Although you focused predominantly on

13 cardiovascular disease, you also saw patients with

14 other types of internal medicine problems; is that

02:12:56 15 correct?

16 A Yes.

17 Q And during that period of time - I'm sure

18 the answer is obvious, but I would like to ask you

19 some questions about some of the diseases you

02:13:10 20 routinely see during your practice - coronary artery

21 disease.

22 A Yes. The question is: Did I see patients

23 with coronary artery disease?

24 Q Yes.

02:13:18 25 A The answer is yes.

51710 5965

02:13:20 1 Q The patients who were at risk for
2 myocardial infarction or had had prior myocardial
3 infarctions?
4 A I saw patients who had myocardial
02:13:34 5 infarctions. I saw patients who had signs or
6 symptoms or the risk factors for the development of
7 coronary artery disease, yes.
8 Q Patients with atherosclerosis?
9 A I saw patients with atherosclerosis, yes.
02:13:50 10 Q Patients who exhibited or -- Strike that.
11 Patients who had peripheral vascular
12 disease?
13 A Yes.
14 Q Did you ever see patients who had a
02:14:00 15 disease called Berger's disease?
16 A No.
17 Q Patients who had intermittent
18 claudication?
19 A Yes.
02:14:10 20 Q Patients who had COPD?
21 A Yes.
22 Q Could you explain to us just for the
23 edification of most of us what COPD is?
24 A Those are letters that stand for chronic
02:14:26 25 obstructive pulmonary disease.

51710 5966

02:14:28 1 Q And this is more of a disease process and
2 finding rather than a separate entity; is that
3 correct?

4 A It's a term used for a group of problems
02:14:40 5 that have to do with respiratory disease.

6 Q Did you see and treat patients with
7 emphysema?

8 A Yes.

9 Q Did you see and treat patients with lung
02:14:54 10 cancer?

11 A Yes. The treatment once the diagnosis was
12 made was then deferred to an oncologist. I would
13 not personally supervise the treatment with the
14 chemotherapy or other modalities for lung cancer.

02:15:12 15 Q But during those periods - those years,
16 you did see patients who came in with lung cancer?

17 A Yes.

18 Q And after your workup, you would refer
19 them out; is that correct?

02:15:20 20 A That's correct.

21 Q Did you follow any of these patients with
22 lung cancer after or during the treatment period?

23 A Yes, for their other medical conditions.

24 Q Patients who had bladder cancer?

02:15:40 25 A Yes. Again, I would see them in a

51710 5967

02:15:44 1 diagnostic role. Once the diagnosis of bladder
2 cancer was made, I would then refer them to an
3 appropriate specialist.

4 Q Patients who had suffered a stroke?

02:15:58 5 A Yes. Again, depending on the situation
6 and the severity of the stroke, I might well have
7 them seen in consultation by a neurologist.

8 Q And this next question will be kind of a
9 generic question on patients: Did you see patients
02:16:20 10 who exhibited the clinical signs of dementia?

11 A Yes.

12 Q Could you explain to us what is meant by
13 "dementia"?

14 A It's an impairment of cognitive function,
02:16:40 15 stated most succinctly.

16 Q Are there a number of different types of
17 disease processes or diseases that can lead to
18 dementia?

19 A Yes.

02:17:04 20 Q In the same context, these diseases that
21 we have just discussed, these were seen in your
22 elderly patient group, as well as the younger group;
23 is that correct?

24 A Yes.

02:17:18 25 Q During the last ten years of practice or

51710 5968

02:17:20 1 for that matter any time during the period of time
2 that you were practicing, did you admit any patients
3 with any of these diseases to nursing homes based on
4 their clinical findings?

02:18:00 5 A Yes, I suspect some in all categories. I
6 can't think of any patient that I -- It's possible.
7 I can't think of a patient that I would have
8 admitted with bladder cancer, but it's possible that
9 that happened.

02:18:18 10 Q But for sure, you did admit patients with
11 cardiovascular disease - various types of
12 cardiovascular disease to nursing homes?

13 A Yes. I would want to clarify that. For
14 example, that might not have been the reason they
02:18:34 15 got admitted to the nursing home; but certainly
16 there were patients in the nursing home that I cared
17 for that had cardiovascular disease. Not addressing
18 specifically why they might have gotten admitted,
19 but the list of diseases that we have discussed,
02:18:46 20 certainly I would have cared for patients in the
21 nursing home who had those conditions.

22 Q And you also admitted patients with those
23 diseases to nursing homes?

24 A I admitted patients with those diseases to
02:18:56 25 nursing homes, yes.

51710 5969

02:19:04 1 Q When any of the patients present to you
2 with cardiovascular disease - or with especially
3 cardiovascular disease, respiratory diseases, or
4 lung cancers in your workup of these patients, do

02:19:24 5 you include in that workup smoking as a possible
6 risk factor in the development of these diseases?

7 A I didn't quite follow the question.

8 Q When you do your history and physical, you
9 stated that you did take a smoking history on your
02:19:40 10 patients.

11 A Yes.

12 Q When you find the presence of COPD,
13 cardiovascular disease, some of the diseases that we
14 mentioned, do you include smoking as a possible
02:19:56 15 causal or risk factor in these diseases?

16 A Yes, certainly it is considered as a risk
17 factor.

18 Q If these patients are current smokers, do
19 you advise them about the hazards of continuing to
02:20:06 20 smoke?

21 A I advise them to stop smoking.

22 Q Why is that, Doctor?

23 A For the reasons we have discussed - that
24 smoking is a recognized risk factor for certain
02:20:28 25 types of health problems.

51710 5970

02:20:30 1 Q And the list of diseases that we have just
2 discussed are some of the diseases in which smoking
3 is considered a risk factor; is that correct?

4 A That's correct.

02:20:44 5 Q When you were practicing -- I know that
6 when I've gone into some doctors' offices, there is
7 always some kind of literature sitting around the
8 office with regard to different public health issues
9 or health issues.

02:20:58 10 In your offices did you have literature in
11 your waiting rooms that talked about or discussed
12 the possible health hazards of smoking?

13 A I don't recall. From time to time we did
14 have such literature, but I have no recollection as
02:21:22 15 to the topics that were covered. It was difficult
16 to keep that sort of thing in stock; so, it would be
17 a minority of the time when such literature was
18 available. It is possible that it had to do with
19 smoking. I don't specifically recall.

02:21:34 20 Q Did you ever provide that literature to
21 any of your patients, specifically the patients who
22 were smokers?

23 A That would not have been a part of my
24 routine, no.

02:21:52 25 Q Would somebody in your office, possibly a

51710 5971

02:21:54 1 nurse, have provided this type of literature?

2 A No, that would have been unlikely. That
3 would not have been a part of our routine. Most of
4 the communications were not by such means, but would
02:22:04 5 have been by instructions.

6 Q Doctor, in the diseases that we
7 discussed - and I think you have already addressed
8 that - but in the diseases we discussed - the
9 coronary artery disease, the atherosclerosis,
02:22:32 10 peripheral vascular disease, COPD, emphysema, lung
11 cancer, dementia - is smoking a risk factor for all
12 of these diseases?

13 A Yes.

14 Q Is it your opinion that smoking is a
02:22:56 15 causal factor in any or all of these diseases?

16 A I'm not an expert in causation; so, I
17 could not address that issue.

18 Q Do you have an opinion whether or not
19 smoking is causal in any of these diseases?

02:23:12 20 A This is not an area of my expertise, and
21 I'm not here to offer such an opinion.

22 Q During your time of practice, have you
23 ever told any of your patients that smoking caused
24 their underlying disease?

02:24:00 25 A No, I don't think so. I would have told

02:24:08 1 them that, again assuming that this list of diseases
2 that you have made to which you have made reference,
3 if I had patients with those disorders that were
4 smokers, the language that I would have been likely
02:24:20 5 to use would have been that these are risk factors
6 for those disorders and they would be well advised
7 to discontinue smoking.

8 Q Dr. Stiles, is smoking a continuing risk
9 factor in the elderly for the development of
02:24:34 10 disease?

11 A Well, for the development of what
12 disease?

13 Q Cardiovascular disease.

14 A Yes. It's not as strong a factor in the
02:24:50 15 elderly as it is in the younger groups.

16 Q What do you base this opinion on?

17 A That's a part of the literature.

18 Q Isn't it true that some of the
19 literature - the more recent literature has shown
02:25:06 20 that smoking continues to be a risk factor for the
21 development of cardiovascular disease even in the
22 elderly?

23 A Possibly in the coronary artery disease,
24 but it's not so with the cardiovascular disorders.
02:25:38 25 Or at least the association is much weaker, perhaps

51710 5973

02:25:40 1 I should say.

2 Q Okay. In the development of cerebral

3 vascular disease, much of the processes that lead to

4 events like strokes or to multiple infarcts or

02:26:02 5 mini-infarcts, these are disease processes that have

6 developed over the years; is that correct?

7 A Those diseases develop over the years,

8 yes, that is correct.

9 Q Specifically with regard to occlusive

02:26:18 10 disease rather than hemorrhagic disease, correct?

11 A Yes.

12 Q And isn't it true that atherosclerosis and

13 hypertension are the two major risk factors involved

14 in the development of infarct and stroke?

02:26:32 15 A You said which? I'm sorry.

16 Q Atherosclerosis and hypertension.

17 A Yes.

18 Q Is smoking a risk factor in the

19 development of atherosclerosis?

02:26:44 20 A Yes.

21 Q Do you know whether or not the smoking is

22 a risk factory in the development or propagation of

23 hypertension?

24 A It is an additive risk factor with

02:26:56 25 hypertension in the development, for example, of

51710 5974

02:27:02 1 coronary artery disease.

2 Q Do you know whether it's a risk factor in

3 the development or the propagation of hypertension?

4 A I'm not as certain of that. I think the

02:27:12 5 answer is yes.

6 Q Do you know whether or not the cessation

7 of smoking reduces the risk of the development of a

8 stroke?

9 A Yes. Excuse me. Yes.

02:28:06 10 Q Dr. Stiles, have you ever read or are you

11 familiar with any of the Surgeon General reports

12 that have come out since 1964?

13 A I have a general knowledge about them.

14 I'm not familiar with them in any detail.

02:28:24 15 Q Have any of these reports specifically

16 addressed the risks or hazards of smoking?

17 A Yes.

18 Q Do you know which ones?

19 A "Ones" being which reports?

02:28:36 20 Q Which years, yes.

21 A No, I don't.

22 Q But there have been several?

23 A Yes.

24 Q Do you remember any of the - the gist of

02:28:48 25 any of these reports?

51710 5975

02:28:54 1 A The gist of them was generally that
2 smoking was a risk factor.

3 Q Do you know if any of these reports
4 specifically address whether or not smoking is a
02:29:16 5 causal factor in the development of lung cancer?

6 A I don't know whether that language was
7 used or not. No, I'm not certain of that.

8 Q Dr. Stiles, you have testified earlier
9 that a great portion of your practice was involved
02:30:04 10 with elderly or geriatric patients. And as such,
11 you have experience with admissions with nursing
12 homes of these patients; is that correct?

13 A Yes.

14 Q Have you ever owned or operated a nursing
02:30:18 15 home?

16 A No.

17 Q Have you ever been on a board of directors
18 or been a medical director of any nursing homes?

19 A I was a medical director for a very short
02:30:36 20 period of time at one home - less than a year, as I
21 recall.

22 Q Which nursing home was that?

23 A It had many names during my -- I can't
24 tell you the name of it.

02:30:54 25 Q Where was it?

51710 5976

02:30:56 1 A It was in the Texas City area.

2 Q Was that the major nursing home that's on

3 the main street in Texas City?

4 A I did -- Oh, in Texas City? No, I did not

02:31:10 5 attend that nursing home.

6 Q But you don't remember the name of this

7 institution?

8 A No, I don't.

9 Q During your practice, where did you admit

02:31:26 10 your patients ---

11 A To the ---

12 Q --- to the nursing homes?

13 A To the nursing homes? There was a nursing

14 home adjacent to our office in Texas City, there was

02:31:44 15 a nursing home on the Gulf Freeway, and there were

16 two nursing homes environs of Texas City and

17 La Marque. I'm not sure which town they were in,

18 but it was in that -- Those two towns run together.

19 And there was a nursing home in Galveston.

02:32:10 20 Q Where was that located?

21 A The one in Galveston was located on the

22 seawall at about 15th Street - no, farther.

23 Q 25th Street?

24 A 23rd, could have been 25th Street. And

02:32:30 25 then there was a nursing home across the street from

51710 5977

02:32:36 1 our office in Friendswood.

2 Q Do you remember or recall the names of any
3 of these nursing homes?

4 A The one on the Gulf Freeway was at one
02:33:00 5 time called Manor Care. And it's come to me now at
6 one time one of the homes in the
7 Texas City-La Marque area was called Autumn Hills.
8 The one in Galveston, I believe, was Moody. Those
9 are the only ones I recall, but the names changed
02:33:28 10 many times during the years.

11 Q Is Autumn Hills the one that was kind of
12 in the newspapers for a while ---

13 A Yes.

14 Q --- in the Eighties?

02:33:42 15 A Yes, I believe that's right.

16 Q In choosing which nursing home to use,
17 what were your criteria to choose those - the
18 proximity of the patient? In other words, you
19 admitted Galveston patients to Galveston; or could
02:34:08 20 you tell us how you chose the nursing homes?

21 A It was almost always the decision of the
22 family.

23 Q In the last five years of your practice,
24 approximately how many patients per year do you
02:34:32 25 recall admitting to nursing homes?

51710 5978

02:34:36 1 A Let me preface that answer by saying that
2 there was some point towards the end of my time in
3 practice where I ceased seeing patients in nursing
4 homes altogether. I don't remember exactly when
02:34:50 5 that was, but I gave up my nursing home practice
6 altogether during some portion of those last few
7 years. I don't remember exactly when that was.

8 So, now with that preface, your question
9 was how many patients would I admit per year?

02:35:04 10 Q Yes.

11 A Oh, I don't know the number for that. I
12 would say somewhere in the range of 50, but it might
13 be 30. It might be more than 50, but somewhere in
14 that range. There were years where I seemed to
02:35:36 15 admit more patients to nursing homes, and then there
16 were other years where I didn't seem to admit as
17 many.

18 Q You stated, Doctor, that in the last few
19 years prior to your cessation of practice, you gave
02:35:50 20 up seeing patients in nursing homes. Why was that?

21 A It's a very time-consuming practice, and I
22 just felt like I did not have the time to continue
23 to do that.

24 Q And you say you quit seeing patients in
02:36:04 25 nursing homes. Did that mean you quit admitting

51710 5979

02:36:06 1 them as patients?

2 A I quit seeing and admitting.

3 Q Could you tell us what your best time
4 estimate on when you quit seeing patients in nursing
02:36:18 5 homes?

6 A I've given you my best estimate. I don't
7 really know.

8 Q Five years?

9 A No, I think it wouldn't have been -- It
02:36:28 10 would not have been that close to retirement. More
11 like maybe three years, but that's a guess.

12 Q Prior to your retirement?

13 A Right.

14 Q Can you tell us what percentage of the
02:37:02 15 patients that you would admit to nursing homes would
16 you initially admit who were Medicare patients?

17 A Well, the answer is, no, I can't really
18 tell you the answer to that. It's not something
19 that I would have kept track of at the time. I

02:37:36 20 would say that the majority were a combination of
21 Medicare and Medicaid, and the minority would have
22 been private-pay.

23 Q Could you tell us of these patients that
24 you admitted, how many were on the average, if you
02:38:00 25 can recall, how many were short-term admits versus

51710 5980

02:38:02 1 long-term admissions?

2 A The majority, I would say, more than
3 50 percent would be long-term.

4 Q Would these, if they were Medicare, roll
02:38:22 5 over into Medicaid patients?

6 A Yes.

7 Q How often did you see your patients that
8 you admitted, on the average?

9 A On the average, once a month.

02:38:50 10 Q Why only once a month?

11 A The patients in nursing homes are for the
12 most part not acute care patients. They are
13 custodial care patients, and that's usually
14 sufficient. I would see them as needed when their
02:39:06 15 condition warranted it.

16 Q Did they also have staff doctors that
17 would see patients?

18 A No, there weren't any such physicians at
19 any of the homes that I went to.

02:39:30 20 Q What is the -- Do you know what the
21 reimbursement rate is for patient visits in the
22 nursing home by Medicaid?

23 A Only in generalities. I think it's in the
24 range of around \$45 a day, something in that range.

02:40:00 25 Q Is this for patient days, or is this

51710 5981

02:40:04 1 reimbursement for you for your medical visits?
2 A No, that would be patient days
3 reimbursement to the nursing home.
4 Q Do you know the rate at which Medicaid
02:40:20 5 reimbursed you for visits of your patients?
6 A No, I don't.
7 Q The \$45 per day that you have just given
8 us, is that an estimate ---
9 A Yes.
02:40:34 10 Q --- or this is not based on something you
11 have read?
12 A Well, I suppose it's to some extent based
13 on something that I have read or that I have known.
14 I have reason -- That's a number that kind of sticks
02:40:46 15 in my head.
16 Q Do you know what the daily reimbursement
17 rate is for Medicare patients?
18 A I believe it's considerably more than
19 that. I think it's in the range of maybe twice
02:40:56 20 that.
21 Q How long can a patient be admitted as a
22 Medicare patient only - as a Medicare-pay patient
23 only to a nursing home?
24 A I don't remember all the rules. There
02:41:18 25 were certain rules about that. They -- you had

51710 5982

02:41:24 1 to -- I believe it's in the range of 30 days; and
2 then as I recall, if there were certain conditions,
3 they might qualify for another 30 days. I can't
4 remember how long that process went on, but that's
02:41:36 5 in general my recollection.

6 Q Was this something that you actually
7 studied to determine how many days your patients
8 could be under Medicare versus Medicaid?

9 A As I recall, it was usually pretty
02:41:56 10 straightforward. Either they qualified - that is,
11 they had some condition which qualified them for the
12 Medicare reimbursement - or they didn't. And this -
13 a lot of that determination was made by the
14 administrators and the people that assisted the
02:42:18 15 administrators in terms of whether they qualified.
16 They were then more knowledgeable about whether a
17 resident would qualify as a Medicaid patient or
18 Medicare patient than I was.

19 Q So, this was something that you left to
02:42:36 20 others - the nursing home administrators and the
21 nursing home people?

22 A They were more knowledgeable about whether
23 the people were going to meet the necessary criteria
24 for that type of thing than I was, yes.

02:42:48 25 Q And you don't know the criteria

51710 5983

02:42:50 1 specifically?

2 A I couldn't quote them specifically, no. I
3 know that there were other criteria. They had to
4 have been in the hospital within - for three days or
02:43:06 5 more; and they had to have been placed in the
6 nursing home after the discharge from the hospital
7 within a certain period of time - I want to say
8 within 30 days. But there were rules like that.

9 Q Was there -- Is there a point that the
02:43:22 10 Medicare patients have to begin paying some type of
11 co-payment?

12 A Yes, I believe that's true.

13 Q Do you know at what point that occurs?

14 A No, I don't.

02:43:38 15 Q Does Medicare pay for long-term stays at
16 nursing homes?

17 A I don't think so.

18 Q Is that covered by Medicaid?

19 A Medicaid.

02:43:52 20 Q Doctor, could you give us what your
21 understanding is of the participation of Medicaid
22 reimbursement in nursing home care?

23 A I'm not sure I understand the question.

24 Q What your understanding is with regard to
02:44:12 25 how Medicaid determines whether or not they are

51710 5984

02:44:16 1 going to reimburse for patient stays or patient care
2 in a nursing home.

3 A I think it has primarily to do with their
4 ability to pay - that is, if they have no resources
02:44:30 5 for reimbursing the home after a certain period of
6 time, that is, either ongoing income or accumulation
7 of resources like a savings in the bank.

8 Q Is Medicaid reimbursement dependent on any
9 way on the diagnostic criteria used to admit that
02:44:54 10 patient?

11 A I'm not sure.

12 Q Let me rephrase that because that was even
13 confusing to me.

14 Does Medicaid reimbursement or Medicaid
02:45:10 15 coverage of patients in nursing homes, is that
16 dependent in any way on the diagnosis - the
17 admitting diagnosis?

18 A I'm not sure of the answer to that.
19 Again, that would be a decision that I would have
02:45:24 20 really depended on other people to be making rather
21 than myself.

22 Q Did you have to fill out certain forms to
23 admit patients to nursing homes?

24 A Yes.

02:45:32 25 Q And on those forms ---

51710 5985

02:45:36 1 A And the forms, however, would be basically
2 filled out by other staff; and I would sign the
3 forms.

4 Q But the admission had to be based on some
02:45:46 5 type of medical criteria; is that correct?

6 A They would contain diagnoses.

7 Q Is that the primary requirement for the
8 admission of a patient under Medicare rules?

9 A I'm not sure.

02:46:12 10 MR. THORPE: Go off the record
11 for a minute.

12 THE VIDEOGRAPHER: We are going
13 off the record. It's 46 minutes
14 after 2:00 o'clock. This is the end
02:46:22 15 of Tape No. 1.

16
17 (A BRIEF RECESS WAS TAKEN.)

18
19 THE VIDEOGRAPHER: It's
02:48:50 20 48 minutes after 2:00 o'clock. This
21 is the beginning of Tape No. 2, and
22 we are back on the record.

23
24 (By Mr. Thorpe)

02:48:58 25 Q Dr. Stiles, in your period of time in

02:49:02 1 which you were involved in admitting patients to the
2 nursing homes, did you ever commit Medicaid fraud or
3 Medicaid abuse?

4 A No.

02:49:20 5 Q Did you ever see or know of anyone at the
6 nursing home or any physicians who committed
7 Medicaid fraud or Medicaid abuse?

8 A No.

9 Q Were you ever aware of any fraudulent
02:49:34 10 billing practices for Medicaid practices in nursing
11 homes you were associated with?

12 A No.

13 Q Did you ever admit a Medicaid patient on a
14 diagnosis just for the purpose of having that
02:49:50 15 patient admitted?

16 A No.

17 Q Dr. Stiles, in the disclosure that was
18 made to us with regard to your testimony today, you
19 listed several cases since 1994 in which you had
02:50:20 20 testified as an expert either by deposition or
21 giving trial testimony and these are three cases and
22 I would like to go over those just briefly.

23 Do you need a copy of this?

24 Are these the only cases in which you have
02:50:42 25 acted since 1994 as a testifying expert?

51710 5987

02:50:48 1 A These are the only cases in which I - it
2 became necessary to give a deposition. I have
3 reviewed other cases, but these are the only cases
4 in which depositions were required.

02:51:00 5 Q Were you hired in other cases as a
6 testifying expert, but never did testify?

7 A I was asked to review cases with the
8 understanding that if it became necessary to give a
9 deposition or testify at trial, that I was willing
02:51:12 10 to do so.

11 Q So, this list is just those in which you
12 have given depositions?

13 A That's correct.

14 Q Could you tell us about the first case
02:51:24 15 that's listed? Where was that filed? It's Bonnie
16 Wils versus Beverly Enterprises.

17 A I don't know. I have no idea. I don't
18 keep that sort of information.

19 Q Do you know whether that was in federal
02:51:38 20 court or state court?

21 A I really don't.

22 Q Do you remember the allegations made in
23 that case?

24 A Yes.

02:51:44 25 Q Could you tell us about that?

51710 5988

02:51:52 1 A Briefly, it was a nursing home resident
2 who was found having fallen out of bed while
3 restrained; and the cause of death was asphyxiation.

4 Q Do you know the outcome of that case?

02:52:20 5 A I believe it settled out of court.

6 Q Who were you hired by in that case?

7 A I will decline to answer that question.

8 Q Plaintiff or defendant?

9 A I was hired by the defense.

02:52:44 10 Q The second case that you listed is Crow -
11 Jessie Crow versus Methodist Hospital.

12 A Yes.

13 Q What was the basis of that case?

14 A The allegation was that the care rendered
02:53:10 15 by the attending physician and consultants was below
16 the standard of care.

17 Q And this was against the physician or the
18 hospital itself?

19 A My services were relative to -- It was all
02:53:28 20 three. It was the hospital, and there were two
21 physicians. They were all sued.

22 Q And who were you hired for or by in that
23 case?

24 A I testified for the plaintiff.

02:53:40 25 Q What was the outcome of that case?

51710 5989

02:53:42 1 A It settled out of court.

2 Q And the third case, Garcia versus Garcia?

3 A This had to do with a -- It involved an

4 automobile accident and a question of alcohol

02:54:10 5 consumption and an injury and it settled out of

6 court and I was retained by the plaintiff.

7 Q The Methodist case - was that in Houston?

8 A I don't remember.

9 Q Beverly Enterprises is in Galveston; is

02:54:38 10 that correct?

11 A No. Well, I don't know where their

12 headquarters is; but they have nursing homes in

13 many, many locations.

14 Q Do you know where that case was filed?

02:54:52 15 A I sure don't.

16 Q And how about Garcia versus ---

17 A But I believe the Methodist Hospital, I

18 believe that was Houston.

19 Q And Garcia versus Garcia?

02:55:04 20 A I don't remember.

21 Q Did you testify here in Houston or

22 elsewhere?

23 A The deposition was taken here in Houston.

24 Q Have you given other depositions in the

02:55:26 25 last five years?

51710 5990

02:55:26 1

A No.

2

Q Prior to the period 1994, had you given
any depositions?

3

A Yes.

02:55:48 5

MR. THORPE: I'd like to mark

6

that.

7

8

(STILES EXHIBIT NO. 1, LIST OF

9

PRIOR TESTIMONY, WAS MARKED FOR

10

IDENTIFICATION. SAME WILL BE FOUND

11

AT THE CONCLUSION OF THIS

12

DEPOSITION.)

13

14

(By Mr. Thorpe)

02:56:10 15

Q Dr. Stiles, with regard to the tobacco
litigation for which we are here today, when were
you first contacted to become or contacted with
regard to giving expert testimony in this case?

16

17

18

19

A It would have been either late April or
early May.

02:56:28 20

21

Q Of 1997?

22

A Yes.

23

Q Who contacted you first?

24

A Mr. James Ebanks.

02:56:50 25

Q Is he a lawyer?

51710 5991

02:56:50 1 A Yes.

2 Q For whom?

3 A Geissel, Lyman, and Barker, I believe.

4 Q Had you worked for this law firm prior to

02:57:12 5 their contacting you?

6 A I had reviewed a case - a previous case.

7 Q Did that case also have something to do

8 with smoking or tobacco?

9 A No.

02:57:36 10 Q Why did they contact you?

11 A I don't know.

12 Q Who hired you as an expert in this case?

13 A I'll be reimbursed by the law firm of

14 Shook, Hardy & Bacon.

02:57:58 15 Q And when did you first meet with the

16 attorneys at Shook, Hardy?

17 A Early May.

18 Q How long after you were first contacted by

19 Mr. Ebanks?

02:58:14 20 A Probably within a week or so.

21 Q What did Shook, Hardy tell you that they

22 wanted with regard to your testimony in this case?

23 A They were interested in whether I had

24 knowledge about why residents are admitted to

02:58:48 25 nursing homes.

51710 5992

02:59:02 1 Q At that time did they supply any documents
2 to you?

3 A No.

4 Q Have you done any research with regard to
02:59:14 5 any of the subject matter that's been covered in
6 this deposition or with regard to the report that
7 was submitted to us?

8 A Yes.

9 Q What documents did you review with regard
02:59:30 10 to these subjects?

11 A I looked at a number of texts that were in
12 my library, and I requested the T.M.A. to supply me
13 with journal articles regarding the topics.

14 Q In the disclosure in this particular
03:00:08 15 litigation, there are requirements to provide us
16 with documents in which you formed your opinion or
17 books and articles that you used in forming your
18 opinion. We were not supplied with any of this
19 material. Did you provide this material to your
03:00:24 20 attorneys?

21 A I'm not relying on any of that information
22 in forming my testimony.

23 Q You used that information to research the
24 information that you are now testifying to; is that
25 correct?

51710 5993

03:00:44 1 A I used it to be informative and helpful
2 and refreshing, but I'm not relying -- My testimony
3 is not based on any of that literature.

4 Q But that information - did you use that as
03:00:54 5 a basis for forming your opinions?

6 A No.

7 Q So, you just read that for your own
8 edification?

9 A For the reasons that I have stated.

03:01:04 10 Q Do you have that material still available?

11 A I still have the textbooks; and, yes, I
12 still have some articles.

13 Q And you're testifying today that you used
14 none of that information that you reviewed in
03:01:26 15 forming any of your opinions that you have given
16 today?

17 A That's correct.

18 Q And, therefore, your opinions are based on
19 what?

03:01:42 20 A They are based primarily on my experience
21 and my previous knowledge of these matters.

22 MR. BORMAN: It is now
23 3:00 o'clock, whenever you would like
24 to take your hourly break.

03:02:00 25 MR. THORPE: It's a good time.

51710 5994

1 We'll take it right now.

2 THE VIDEOGRAPHER: We are going
3 off the record. It is one minute
4 after 3:00 o'clock.

03:02:16 5

6 (A BRIEF RECESS WAS TAKEN.)

7

8 THE VIDEOGRAPHER: It's 14
9 minutes after 3:00 o'clock; and we
03:14:14 10 are back on the record.

11 (By Mr. Thorpe)

12 Q Dr. Stiles, just before we took a break,
13 we were talking about what documents that you relied
14 on in forming your opinions. And you stated that
03:14:28 15 you did not rely on any of the materials that you
16 reviewed in forming your opinion; is that correct?

17 A Yes.

18 Q And you have stated also - and correct me
19 if I'm wrong - that you are limiting your opinions
03:14:42 20 to your prior experience in this particular area; is
21 that correct?

22 A Well, my prior experience and my general
23 knowledge of the field. And as I said, the
24 materials that I read were useful and informative
03:14:58 25 and helpful; but I'm not relying on them as a basis

51710 5995

03:14:58 1 of my opinion.

2 Q So, you are limiting your opinions based
3 on your experience in the field of gerontology; is
4 that correct - gerontology and your experience and
03:15:18 5 your nursing home experience in your own private
6 practice?

7 A I'm not sure I understand how that
8 question is different than the one I just answered.

9 Q I'm just trying to find out what you are
03:15:32 10 basing your opinions on and what you based your
11 opinions on with regard to the report that was
12 submitted to us.

13 And would you again state what you are
14 basing those opinions on and what materials or what
03:15:46 15 knowledge you are basing them on.

16 A I'm basing my opinion on my experience and
17 knowledge in the field of internal medicine and
18 gerontology. As I have said, I'm not relying on the
19 literature that we have just discussed as the basis
03:16:04 20 for my opinion. They were useful and helpful and
21 informative.

22 Q Did any of the attorneys or anyone else in
23 this particular litigation provide you with any
24 materials?

03:16:30 25 A Yes.

51710 5996

03:16:32 1 Q Who was that?
2 A Ms. Lewis.
3 Q What materials were provided by Ms. Lewis?
4 A They provided some journal articles.
03:16:50 5 Q Could you tell me what these journal
6 articles pertained to?
7 A They pertained primarily to nursing homes
8 and admission to nursing homes.
9 Q Where were these articles published?
03:17:22 10 A In numerous recognized medical journals.
11 I don't remember which ones specifically; but they
12 were ones, as I reviewed them, I recognized.
13 Q Did you rely on any of these materials in
14 forming your opinion?
03:17:36 15 A They were helpful and useful and
16 informative, but I did not rely on them to form any
17 of my opinions.
18 Q In any of the materials that you gathered
19 yourself, did you provide those materials to any of
03:18:02 20 the attorneys or anyone else associated with this
21 litigation?
22 A Yes.
23 Q What materials did you provide to your
24 attorneys or to the attorneys you are working with?
03:18:28 25 A I provided some journal articles; and I

51710 5997

03:18:30 1 believe they were the ones, as I recall, that had
2 come from the T.M.A.

3 Q And these -- Did you do this after you
4 were hired as an expert in this case?

03:18:42 5 A Yes.

6 Q How much are you being paid as an expert
7 in this case?

8 A \$500 an hour.

9 Q How much have you been paid to date for
03:19:18 10 your preparation for testimony in this case?

11 A I've not submitted a bill.

12 Q Do you keep a ledger, or do you keep some
13 type of notes with regard to the amount of time that
14 you have spent in this case?

03:19:36 15 A I keep notes.

16 Q Do you have those notes with you today?

17 A No.

18 Q In reviewing any of the materials that you
19 say are helpful and useful and informative, did you
03:19:56 20 keep any notes on when you were reviewing this
21 material?

22 A No.

23 Q Did you make any notes in preparation for
24 your testimony today or your testimony later at
03:20:12 25 trial?

51710 5998

03:20:14 1 A No.

2 Q Were you asked not to keep notes?

3 A Not that I recall.

4 Q Is this a practice that you have in any of

03:20:24 5 the consulting work that you do?

6 A Yes.

7 Q How many times have you met with the

8 attorneys involved in this case since May of - I

9 believe it's May of 1997?

03:20:50 10 A Four or five times.

11 Q You stated that you met - shortly after

12 you were contacted by Mr. Ebanks, you met with

13 Shook, Hardy; is that correct?

14 A Yes.

03:21:12 15 Q Who did you meet with?

16 A Mr. Ebanks was there; Ms. Lewis was there;

17 another attorney from Shook, Hardy. I believe his

18 name was Clyde Curtis, I believe.

19 Q What was discussed at that meeting and

03:21:36 20 when did it occur and where did it occur?

21 A It occurred in the offices of Mr. Ebanks,

22 it occurred sometime in early May, and we discussed

23 what - why they were interested in my area of

24 expertise relative to why residents might end up

03:22:04 25 being in a nursing home.

51710 5999

03:22:16 1 Q What did you tell them?

2 A I told them that I had some experience in

3 that area.

4 Q What else did you discuss at that time?

03:22:42 5 A That's all I can recall right now.

6 Q Well, was there anyone else in attendance

7 other than the three lawyers?

8 A I don't believe so.

9 Q When was the next time that you met with

03:23:02 10 anyone involved in this litigation?

11 A Well, we met sometime later. I don't

12 remember. It would have been a week or two. I

13 don't remember exactly. Again, I believe it was

14 Ms. Lewis and Mr. Curtis; and Mr. Ebanks may have

03:23:44 15 been there. I believe that was also in his office.

16 Q Here in Houston?

17 A Yes.

18 Q What was discussed at that period?

19 A Again, we talked about my opinion; and I

03:24:14 20 believe it was at that meeting that we discussed a

21 statement that was necessary for us to provide you.

22 I don't know the official name of that. It was

23 necessary for us to provide you with the general

24 topics about which I would be testifying.

03:24:36 25 Q Had a statement been prepared for you to

51710 6000

03:24:38 1 evaluate at that time?

2 A There was a draft of a statement, yes.

3 Q Do you still have that draft?

4 A No.

03:24:50 5 Q Why not?

6 A I didn't keep a copy.

7 Q Did you take a copy of that draft out of
8 the office on that day?

9 A I did not.

03:25:00 10 Q Did you make changes to that draft at that
11 time?

12 A Yes.

13 Q Who did you leave that draft change with?

14 A Ms. Lewis.

03:25:20 15 Q Who prepared the original draft?

16 A I don't know.

17 Q Was it prepared by lawyers in Shook,
18 Hardy?

19 A That would be my assumption, but I

03:25:36 20 don't -- The answer is I don't know.

21 Q You did not prepare that draft?

22 A I did not.

23 Q Had you spoken to anyone on the telephone
24 prior to the second meeting with regard to this

03:25:54 25 litigation?

51710 6001

03:26:00 1 A It's quite possible. I don't recall.
2 Q Do you keep a log of phone calls that are
3 made with regard to this case?
4 A Sometimes.
03:26:10 5 Q Do you charge for a telephone
6 conversation?
7 A If they are of any length.
8 Q What do you by "any length"?
9 A 10 or 15 minutes.
03:26:22 10 Q So, any time that there is a conversation
11 10 or 15 minutes or greater, you log that down?
12 A I try to.
13 Q And you, again, would have that log with
14 your other notes with regard to your fee?
03:26:38 15 A I have that with the information regarding
16 the fee.
17 Q Do you know how many times you may have
18 spoken with someone prior to the second meeting,
19 with regard to this case obviously?
03:27:00 20 A I don't think it would have been many
21 times, but it could have been two or three. I don't
22 recall.
23 Q What were the nature of the conversations
24 you had and with whom?
03:27:12 25 A They would have all been along the same

51710 6002

03:27:16 1 lines that we have just discussed, and to my
2 recollection they would have all been with
3 Ms. Lewis. I believe that's accurate.

4 Q You don't recall talking with anyone else
03:27:34 5 other than Ms. Lewis?

6 A I don't believe so.

7 Q When was the next time you met with the
8 attorneys in this case?

9 A I don't believe I met with them again then
03:28:04 10 until real early July.

11 Q Who was present at that meeting?

12 A Ms. Lewis and another attorney, and I
13 believe his name was Tom Duncan.

14 Q Do you know where he was from - from which
03:28:20 15 firm?

16 A I do not.

17 Q Was anyone else present?

18 A No.

19 Q Where was this meeting held?

03:28:30 20 A In Pecos, New Mexico.

21 Q Pardon?

22 A Sorry. In Pecos, New Mexico.

23 Q Where is Pecos, New Mexico?

24 A It's near Santa Fe.

03:28:52 25 Q Was there a reason to pick that site for

03:28:52 1 your meeting?

2 A That's where I was at the time.

3 Q Where did you meet in Pecos?

4 A At a monastery.

03:29:10 5 Q I think I'm just going to leave this one.

6 MR. THORPE: They let you into a

7 monastery?

8 A You asked the question.

9 Q What was the nature of the conversation at

03:29:24 10 this time?

11 A We again discussed further really the same

12 topics that I have already mentioned - why are

13 residents admitted to nursing homes, what

14 precipitates their family or their circumstances to

03:29:50 15 elect their going into a nursing home.

16 Q Was another draft of your opinions

17 presented to you at that time?

18 A No.

19 Q Between that meeting and the prior meeting

03:30:08 20 how many phone calls - telephone calls - did you

21 participate in with regard to this case?

22 A Well, there weren't many. Ms. Lewis did

23 contact my wife. It was extremely difficult to get

24 in touch with me. So, arrangements were made

03:30:34 25 through Ms. Lewis and her contacting my wife and my

03:30:36 1 contacts with my wife in terms of arranging that
2 meeting. So, I don't know how many phone calls they
3 had; but I would guess it was two or three phone
4 calls. And during that period of time, I would not
03:30:54 5 have talked with her on the phone.

6 Q After the meeting you had with the
7 attorneys in Pecos, when was the next time that you
8 met with anyone involved in this case?

9 A That would have been shortly after the
03:31:26 10 15th of July, within a few days after that. I don't
11 remember the -- It could have been the 18th, the
12 19th, something like that.

13 Q Who did you meet with at that time?

14 A Ms. Lewis, Mr. Borman.

03:31:42 15 Q Pardon?

16 A Mr. Borman, Carol Braun.

17 Q Who is Ms. Braun?

18 A She is an attorney.

19 Q For whom?

03:31:56 20 A I don't know.

21 Q Anyone else there?

22 A Carol Braun is an attorney for Shook,
23 Hardy. There was another attorney there that I
24 didn't know for sure whether she was with the Shook,
03:32:22 25 Hardy firm or not - her name was Lucy Eisenberg -

51710 6005

03:32:32 1 and this attorney at the end of the table, whose
2 name I still don't remember, for a portion of that
3 meeting.

4 Q Jane?

03:32:44 5 A Yes.

6 I believe that's all.

7 Q What was discussed at that meeting?

8 A At that meeting we discussed the second
9 statement of my opinion regarding what I was
03:33:12 10 retained to testify about. A draft of a statement
11 had been prepared, which was then discussed.

12 Q Did you make changes of that draft during
13 that meeting?

14 A Yes.

03:33:44 15 Q Who prepared the second draft or the
16 second statement that you worked on at that time?

17 A I believe Ms. Lewis prepared it. Whether
18 it was solely at her authorship or not, I don't know
19 the answer to that. But I know that she was, if not
03:34:02 20 the sole author, she was the major contributor.

21 Q Do you know if anyone else might have
22 contributed?

23 A I don't know.

24 Q Was this a modification of the original
03:34:14 25 draft that you discussed earlier?

51710 6006

03:34:14 1 A No.

2 Q This is a totally separate draft?

3 A It was a totally separate draft.

4 Q And I think you testified earlier that you

03:34:28 5 do not know who has the original draft?

6 A I did not -- I did not or do not have a

7 copy of the draft. Who has it, I don't know. It

8 was present in the room when I left; but who left

9 with it, I don't know.

03:34:58 10 Q When you left that day, did you take a

11 copy of this second draft of your opinion or

12 statement?

13 A No.

14 Q Who did you leave that with?

03:35:10 15 A Again, it was left in the room. I assume

16 that Ms. Lewis was in charge of that, but that is an

17 assumption.

18 Q And that second draft that we are talking

19 about contained the changes that you made with

03:35:22 20 regard to that statement; is that correct?

21 A Yes.

22 Q Where was that meeting held?

23 A In the offices of Shook, Hardy.

24 Q Here in Houston?

03:35:42 25 A Yes.

51710 6007

03:35:50 1 Q Do you know why the meeting was changed
2 from Shook, Hardy - or from Mr. Ebanks office to
3 Shook, Hardy?
4 A I do not know.

03:36:04 5 Q When was the next time that you met with
6 anyone involved in this case?
7 A Let's see. We met Monday.
8 Q Was that meeting held here in Houston?
9 A Yes.

03:36:22 10 Q At Shook, Hardy?
11 A Yes.
12 Q Who was present at that time?
13 A Carol Braun, Mr. Borman, and Ms. Lewis and
14 that's all.

03:36:46 15 Q In your previous meeting at Shook, Hardy,
16 do you know why Ms. Eisenberg was present?
17 A No.
18 Q Or any of the other attorneys you hadn't
19 met with before?

03:37:00 20 A No.
21 Q During this meeting what did you discuss?
22 A We discussed, again, my opinion about the
23 matters at hand.
24 Q Could you give me a little more detail?
03:37:22 25 It's really rather vague.

51710 6008

03:37:24 1 A We discussed my opinion about why
2 residents are admitted to nursing homes. We also
3 discussed what topics you might be interested in in
4 your taking of the deposition today.

03:37:46 5 Q What topics did the attorneys say that we
6 might be interested in asking you about?

7 A Well, we talked about your interest in
8 smoking as a risk factor and its relationship to a
9 number of diseases.

03:38:18 10 Q Did you speak or discuss specifically any
11 diseases?

12 A Yes.

13 Q Which diseases?

14 A Many of the ones that we have already
03:38:26 15 mentioned.

16 Q Did you also discuss smoking risks in
17 terms of diseases of the elderly?

18 A Yes.

19 Q What specifically did you talk about with
03:38:48 20 regard to these two topics?

21 A One of the things that we talked about was
22 a topic that we have already discussed. And that is
23 the fact that there seems to be a weaker
24 relationship between smoking as a risk factor in the
03:39:26 25 elderly as relates to cerebral vascular disease,

51710 6009

03:39:26 1 strokes.

2 Q Were any research papers or medical
3 literature provided to you at that time regarding
4 that issue?

03:39:34 5 A No.

6 Q Did the attorneys that you spoke with talk
7 about any studies that directly related to those
8 issues?

9 A Not that I recall.

03:39:52 10 Q What other issues or what other topics
11 were discussed with you with regard to possible
12 areas of questions that we might ask?

13 A Many of the things that we have talked
14 about - my background, my education, experience that
03:40:26 15 I have had with nursing home patients. My
16 experience in practice in general both relates to
17 the office practice, the hospital practice, and the
18 nursing home practice.

19 Q Were any documents or materials provided
03:40:40 20 to you at that time with regard to possible topics
21 we might ask?

22 A No.

23 Q Were any written questions provided to
24 you?

03:40:48 25 A No.

51710 6010

03:40:52 1 Q What other issues were discussed during
2 that meeting?
3 A That's all I recall right now.
4 Q Were there any phone calls between your
03:41:14 5 meeting around the 15th and the meeting I assume was
6 yesterday; is that correct?
7 A There may have been one about firming up
8 the time and the place, as I recall; but that's the
9 only one I recall.
03:41:38 10 Q During the last meeting you had yesterday
11 with the folks involved in this case, did you go
12 over the written opinion that was provided to us in
13 your disclosure?
14 A The two documents that I have made
03:41:52 15 reference to?
16 Q Yes.
17 A Well, I don't know that I would say that
18 we went over them. They were there. It seems that
19 we may have made reference to them as a part of the
03:42:18 20 discussion; but in answer to your question, no, we
21 didn't go over them.
22 Q Were any of the areas in which you have
23 stated an opinion discussed at that time?
24 A I'm sorry. I'm not sure I understand.
03:42:36 25 Q The opinions that you have listed in your

51710 6011

03:42:40 1 disclosure - were any of those opinions discussed
2 during that last meeting?

3 A Yes, I'm sure they were.

4 Q But not specifically reading from the
03:42:48 5 disclosure? That is what you are saying?

6 A I'm not certain that we actually spent any
7 time reading from the disclosure documents, per se;
8 although we might have made an occasional reference
9 to it.

03:43:16 10 Q Other than the attorneys that you have
11 listed in the meetings that you attended either at
12 Shook, Hardy or one of the other law firms, have you
13 discussed this case with anyone else?

14 A No.

03:43:34 15 Q Have you met with or discussed this case
16 with any other physicians or medical people with
17 medical knowledge?

18 A No.

19 Q Have you discussed any of the issues with
03:43:50 20 regard to this case with anyone involved in nursing
21 home administration?

22 A No.

23 Q Were you ever provided with any of the
24 tobacco industry's internal studies about the danger
03:44:08 25 of tobacco during your pendency of this litigation?

51710 6012

03:44:12 1 A I was not provided with any internal
2 documents from the tobacco industry.

3 Q Dr. Stiles, you have give deposition
4 testimony prior to this. Are you familiar with
03:44:38 5 deposition notices that are sent out with regard to
6 when and where depositions are going to be taken?

7 A I would have a layman's knowledge about
8 them, yes.

9 Q You are not provided with the notice
03:44:50 10 itself; is that correct?

11 A I guess there have been times, perhaps I
12 was. Yeah, I think so, at times.

13 Q With regard to this deposition today, were
14 you provided a notice of this deposition?

03:45:08 15 A I saw it yesterday.

16 Q Okay. At the time that you saw the
17 deposition yesterday, were you also provided with
18 the subpoena duces tecum attached to that notice?
19 It's entitled Exhibit A.

03:45:32 20 A I don't think so.

21 Q This is the document that I'm referring
22 to. Have you seen that document that was attached
23 to any one of the deposition notices?

24 A Yes. I didn't recognize it by your
03:45:50 25 description.

51710 6013

03:45:50 1 Q And you saw that yesterday ---

2 A Yes.

3 Q --- is that correct?

4 The subpoena duces tecum asks you to

03:46:02 5 provide or bring a number of different documents.

6 And since you have seen this, I would like to go

7 over these documents and see -- Rather than spend

8 some time or some of our time going over that, were

9 any documents that were requested in this subpoena

03:46:26 10 duces tecum - have you brought any today?

11 A I brought two documents that I believe you

12 have previously received these. These are the

13 copies of the two statements. I believe you have

14 received these before. This is all that I brought

03:46:42 15 with me today.

16 Q Were there any other documents that were

17 responsive to this request?

18 A No.

19 Q And you say that you have some type of

03:47:02 20 notes or documents with regards to your time that

21 you have spent in this case?

22 A Yes.

23 Q And you did not bring that today; is that

24 correct?

03:47:08 25 A That's correct.

51710 6014

03:47:10 1 Q But that is available?

2 A Yes.

3 MR. THORPE: I'd like to mark
4 this.

5
6 (STILES EXHIBIT NO. 2, THE
7 SECOND AMENDED DEPOSITION NOTICE, WAS
8 MARKED FOR IDENTIFICATION. SAME WILL
9 BE FOUND AT THE CONCLUSION OF THIS
10 DEPOSITION.)
11

12 MR. THORPE: I'll state that
13 this is the amended deposition notice
14 that was sent out yesterday. The
03:47:30 15 subpoena duces tecum is the same as
16 the prior deposition notice. This
17 one simply states the time and date,
18 as well as the subpoena duces tecum.
19

20 (By Mr. Thorpe)

21 Q (Tendering) Dr. Stiles, I'd like you to
22 look at this document.

23 A (Reviewing) Yes.

24 Q Have you seen that document prior to
03:49:02 25 today?

51710 6015

03:49:12 1 A The words in this document are the same at
2 first reading as the words in this document. I'm
3 not aware of seeing it in this format.

4 Q You have never seen that particular
03:49:24 5 document prior to this as it's written?

6 A I don't think so.

7 Q As foundation, this is a document that was
8 provided by some of the defendants in this case as a
9 preliminary report of your opinions. Did you
03:49:52 10 prepare this document?

11 A No, I did not.

12 Q And you have not seen this document prior
13 to today in this form?

14 A Again, as I repeat myself, I don't recall
03:50:08 15 seeing it in that form. It's possible, but I don't
16 recall seeing it in any form other than this
17 particular format.

18 Q Was this the document you referred to as
19 the first draft that you saw some time ago?

03:50:22 20 A No.

21 Q So, this is entirely separate?

22 A Yes. And, again, let me preface my
23 remarks. I have not compared that document with
24 this document word for word. It appears that they
03:50:38 25 are the same. If they are the same, then what that

51710 6016

03:50:40 1 says is what this says. And I don't recall seeing
2 it in that particular spacing and so forth.

3 Q So that we can be specific, could you take
4 some time to take a look at those two documents ---

03:50:50 5 A Sure.

6 Q --- and tell me if they are the same or
7 different?

8 A (Witness complies) It is the same. I
9 don't recall that a draft was finalized while I was
03:52:00 10 present when this was concluded. That's a
11 possibility. I don't recall that as happening, but
12 I suppose that's a possibility this was mailed to
13 me.

14 Q The document -- That was going to be my
03:52:10 15 question: When did you first receive this document?

16 A Ms. Lewis mailed it to me some time after
17 the meeting at which it was constructed.

18 Q And when you say that "it was
19 constructed" ---

03:52:20 20 A Within a few days.

21 Q --- when was that?

22 A Again, we would have to sort of refer to
23 my previous sequence of events; but it was after one
24 of the early-on meetings.

03:52:34 25 Q But you also -- Is it your testimony that

51710 6017

03:52:38 1 this was not the first draft that you testified
2 earlier?

3 A That's correct. That is not the first
4 draft.

03:52:44 5 Q And you do not have a copy of what we
6 referred to as the first draft?

7 A I do not.

8 Q And you do not know when you first
9 received this; is that correct?

03:52:56 10 A I can't ---

11 Q Or the document that you have?

12 A I know that I received this some time
13 after that date. I couldn't tell you exactly when.
14 It was just mailed to me.

03:53:10 15 Q This is not a document that you were -
16 that you discussed during any of your meetings; is
17 that correct?

18 A Now, by "document" if you mean the words
19 in this document, the words in this document were
03:53:26 20 discussed at the meeting. I do not recall seeing
21 this document in this particular format at any
22 time. It's possible that maybe they drafted it
23 while I was there. I don't remember that occurring.

24 Q And you don't know who drafted it?

03:53:40 25 A And I don't know who drafted it.

51710 6018

03:53:40 1

MR. THORPE: Mark that as an
Exhibit.

2

3

4

5

6

7

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9

03:53:48 10

MR. THORPE: Before we go into
his report, do you want to take a
break?

11

12

13

14

03:53:54 15

MR. THORPE: I think so.

16

17

18

19

20

(A BRIEF RECESS WAS TAKEN.)

21

22

23

24

25

THE VIDEOGRAPHER: It's
two minutes after 4:00 o'clock; and
we are back on the record.

51710 6019

1 (By Mr. Thorpe)

2 Q Dr. Stiles, as part of the disclosure that
3 we were provided from the defendants in this case is
4 a report entitled "Charles M. Stiles, M.D., List of
04:03:34 5 Expert Opinions." You brought today a document with
6 you. Is that the same document?

7 (Tendering) The copy that I'm providing
8 you is a fax copy of your report.

9 A (Reviewing) Yes.

04:03:56 10 MR. THORPE: I'd like to have
11 this marked.

12
13 (STILES EXHIBIT NO. 4, LIST OF
14 EXPERT OPINIONS, WAS MARKED FOR
15 IDENTIFICATION. SAME WILL BE FOUND
16 AT THE CONCLUSION OF THIS
17 DEPOSITION.)
18

19 (By Mr. Thorpe)

04:04:20 20 Q I'd like to ask the questions from the
21 document we have marked.

22 Dr. Stiles, when was the first time that
23 you saw the document that is marked as Exhibit No.
24 4?

04:04:44 25 A It was mailed to me at some time after the

04:04:48 1 meeting at which this was discussed. I can't tell
2 you exactly when that would have been, but it would
3 have been - it would have been after the 15th. I
4 believe our meeting was something like the 18th or
04:05:08 5 19th; so, it would have been some time after that.

6 Q After your meeting?

7 A Uh-huh, on the 18th or 19th.

8 Q Was a draft of that document presented to
9 you at that particular meeting that you have just
04:05:22 10 discussed on the 18th or 19th?

11 A Let me make sure that we are clear. When
12 I went to that meeting, the document with this title
13 had been constructed. It was at that meeting that
14 changes were made in that document. I did not while
04:05:44 15 at the meeting see a copy of the revised, retyped
16 document.

17 Q And you have testified earlier that you do
18 not have a copy of the draft that you revised; is
19 that correct?

04:05:54 20 A I did not and do not.

21 Q And some time after that meeting you were
22 sent the revised ---

23 A I believe you may have misspoke yourself,
24 and I agreed with you. You said the "revised"
04:06:08 25 document. The document that was the original of

51710 6021

04:06:12 1 this document is the document that I did not or do
2 not have a copy of. I was sent a copy as it was
3 revised.

4 Q Okay. And this was the document that was
04:06:24 5 provided to us as the list of your opinions in this
6 case; is that correct?

7 A Yes.

8 Q And in your meeting yesterday with the
9 attorneys, did you have a copy of that document with
04:06:36 10 you?

11 A I believe I had this with me.

12 Q And you have testified earlier that some
13 of the issues were discussed at that meeting; is
14 that correct?

04:06:52 15 A Yes.

16 Q I'd like to go through the categories that
17 you listed with regard to your opinions - expert
18 opinions in this case. The first issue that you
19 address are biological mechanisms of aging.

04:07:18 20 Did you use any documents or any research
21 materials to formulate your opinions with regard to
22 the statements you have made in this particular
23 category?

24 A No.

04:07:28 25 Q What did you base your opinions on in

51710 6022

04:07:32 1 formulating - or in formulating your opinions?

2 A My knowledge and experience.

3 Q Have you ever done any research in the
4 field of aging?

04:07:40 5 A No.

6 Q Have you published anything in the field
7 of aging?

8 A No.

9 Q You state in this particular category that
04:07:58 10 aging is not a disease, but a biological change over
11 time in the function of various organs and tissues
12 in the body.

13 Could you tell us what you mean by that,
14 Doctor?

04:08:12 15 A The aging process is not a disease
16 process. It is a process that occurs because of
17 aging, not some superimposed added disorder.

18 Q And in the statement are you addressing
19 aging in general or in patients that are in nursing
04:08:36 20 homes?

21 A It's not -- This statement is not
22 confined.

23 Q Do the risk factors or any or all of the
24 risk factors that we have talked about earlier - do
04:08:58 25 they have any impact on the aging process?

51710 6023

04:09:30 1 A No. The two are really separate. The
2 risk factors that we have discussed may place an
3 individual at a higher risk for the development of
4 specific disorders, but the process of aging is an
04:09:50 5 independent process.

6 Now, I'll stop there.

7 Q And, so, the risk factors still influence
8 disease states as you age; is that correct?

9 A They may.

04:10:12 10 Q In your discussion of the biological
11 mechanisms, one of things that I think is an issue
12 is wear and tear. Have you ever read or studied
13 anything about wear and tear with regard to the
14 aging process?

04:10:30 15 A Wear and tear is a part of the aging
16 process relative to particularly certain structures.

17 Q And some of the influences on the
18 so-called wear and tear theory are environmental
19 factors?

04:10:58 20 A Yes, I think so.

21 Q In that first paragraph you also state
22 that aging may render an individual susceptible to
23 disease.

24 Can you tell us what you meant by that
04:11:14 25 statement, Doctor?

51710 6024

04:11:18 1 A There are processes -- Let me rephrase
2 that. Aging results in the decline in certain organ
3 functions which may make an individual more
4 susceptible to other factors.

04:11:40 5 Q And, so, in that same light, then,
6 patients who have possibly underlying chronic
7 diseases, say COPD, are more susceptible to the
8 development of pneumonia?

9 A People who have chronic obstructive
04:12:04 10 pulmonary disease are more susceptible to pneumonia,
11 yes.

12 Q And you have earlier testified that COPD
13 is a disease that is seen in the elderly population,
14 correct?

04:12:16 15 A It is seen in the elderly population and
16 the not so elderly.

17 Q You state in the next paragraph that
18 common disease processes are influenced in their
19 rate of progression by the age of the patient.

04:12:46 20 What do you mean by that, Doctor?

21 A I think the example that follows is as
22 good as example as I can think of at the moment as
23 it goes on to say that there are certain
24 malignancies, for example, such as breast and
04:13:04 25 prostate cancer. And the rate of these is often --

51710 6025

04:13:08 1 The rate of growth is often less, many times are
2 less aggressive tumors in the older-age person as
3 opposed to the younger-age person.

4 Q Is it your experience that this is true in
04:13:22 5 patients who are diagnosed with lung cancer?

6 A I have seen some patients with - elderly
7 patients with lung cancer where the progression of
8 the growth of the tumor was remarkably slow.

9 Q What type of lung tumor was that?

04:13:50 10 A The particular patient that comes to mind
11 was never tissue-diagnosed.

12 Q So, you don't know whether it was an
13 adenocarcinoma or squamous cell carcinoma?

14 A I could not answer that question.

04:14:04 15 Q Is this the exception or the rule in lung
16 cancer?

17 A In lung cancer the effect of age is
18 perhaps less than in certain other -- It's certainly
19 less than in certain other types of malignancies
04:14:18 20 such as the ones that I've listed here.

21 Q Elderly patients that have cardiovascular
22 disease - is this statement true with those
23 patients?

24 A No.

04:15:00 25 Q The next paragraph you talk about the

51710 6026

04:15:06 1 possibility or the interaction of genetic factors as
2 being critical in both aging and predisposition of
3 disease.

4 Could you tell us what you meant by that
04:15:14 5 statement?

6 A I think we all appreciate that people seem
7 to experience the aging process at different rates.
8 There are people who for their chronological age
9 seem to be much older than others of the same age.

04:15:40 10 Q The genetics haven't been worked out in
11 this completely; is that correct?

12 A That's correct.

13 Q But we know that there is a certain
14 genetic predisposition to diseases?

04:15:52 15 A Yes.

16 Q Is this part of the aging process, or is
17 this something that is predetermined much earlier
18 than the aging process?

19 A "This" being?

04:16:04 20 Q The genetic influence in predisposition to
21 disease.

22 A Could you state the question again.

23 Q You state under the topic of "Biological
24 Mechanisms of Aging," you talk about genetic factors
04:16:18 25 are critical in aging and predisposition to

51710 6027

04:16:20 1 disease.

2 Can you give us examples or instances of
3 genetic factors that influence a patient's
4 predisposition to disease as he gets older - he or
04:16:34 5 she gets older?

6 A The genetic factors are present as a part
7 of their gene makeup. So, those factors are not
8 something that happens later in life. So, that
9 factor is one which we inherit.

04:17:06 10 Q In your example you give Huntington's
11 Chorea as a familial type of disease; is that
12 correct?

13 A Right. Right. Right.

14 Q The expression of Huntington's Chorea, is
04:17:16 15 that something that is expressed in elderly
16 patients; or does that disease usually manifest
17 itself much earlier?

18 A It comes on much earlier than what we
19 would call elderly.

04:17:32 20 Q And do these patients tend to live into
21 ages after 65?

22 A No.

23 Q Are there examples of familial
24 relationships in Alzheimer's disease?

04:17:40 25 A Yes.

51710 6028

04:17:42 1 Q Do you know what percentage of patients
2 who have Alzheimer's disease also have familial
3 history either of dementia or other Alzheimer's?

4 A I've seen a variety of number from - and
04:17:58 5 it seems to be more prominent if it manifests
6 earlier in the ranges of - from 5 to 15 percent; but
7 it's been variously reported.

8 Q Do you know if it goes as high as 25
9 percent?

04:18:10 10 A I'm not certain. I've seen a number that
11 high. It seems like maybe I saw some report of 20
12 percent, but I don't remember a report of 25
13 percent.

14 Q You also talk about genetic factors as
04:18:26 15 influencing susceptibility to diseases; is that
16 correct?

17 A Uh-huh.

18 Q In a patient who develops a disease - and
19 we will pick an example of cardiovascular disease,
04:18:44 20 coronary artery disease - are there studies that
21 show that there is a disease - or a genetic
22 predisposition to this development?

23 A Yes.

24 Q Are external risk factors still operative
04:18:56 25 in the development of these diseases even in

51710 6029

04:18:58 1 patients who are not genetic - shown to be
2 genetically susceptible?

3 A Yes.

4 Q And smoking is one of those risk factors?

04:19:04 5 A Yes.

6 Q Is it fair to say, Doctor, that various
7 risk factors that we have discussed today interact
8 or can interact with the aging process to increase a
9 person's susceptibility to the development of
04:19:38 10 disease?

11 A Yes.

12 Q The next area that you list in terms of
13 your opinions are cognitive impairment in elderly
14 population.

04:20:08 15 Could you define for us -- We talked about
16 it earlier. Could you define for us what is meant
17 by cognitive impairment, or what you mean by
18 cognitive impairment?

19 A It has to do with thinking and our
04:20:22 20 functions of being able to think in what we consider
21 normal ways - our ability to reason, our ability to
22 speak, our ability to perform motor functions.
23 There are many areas of cognition.

24 Q In the elderly, Doctor, are there many
04:20:58 25 causes of cognitive impairment?

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04:20:58 1 A Yes.

2 Q Could you list some of the different
3 causes other than the Alzheimer's and Parkinson's
4 that you have referred to?

04:21:10 5 A Yes.

6 Q There are others?

7 A Yes.

8 Q What's the relationship of the term
9 "dementia" to cognitive impairment?

04:21:30 10 A Cognitive impairment is a part of the
11 definition of "dementia." By "dementia," we mean
12 that the person has some degree of cognitive
13 impairment.

14 Q And, so, cognitive impairment is a common
04:21:50 15 feature in patients who have been diagnosed with one
16 form of dementia or another; is that correct?

17 A Yes.

18 Q Are there dementias associated with
19 cardiovascular disease?

04:22:02 20 A Yes.

21 Q Are there dementias associated with
22 stroke?

23 A Yes.

24 Q I've read the term "MID" with regard to
04:22:18 25 stroke or infarcts and dementia, and I think it's

51710 6031

04:22:20 1 called multiple infarct dementia.

2 A Yes.

3 Q Could you explain to us what that is -
4 what multiple infarct dementia is?

04:22:32 5 A That's a disorder where in a step-wise
6 fashion because of - and I will use a commonly used
7 term - "little strokes," a person suffers step-wise
8 progressive loss of cognitive function.

9 Q Are there multiple disease processes that
04:22:58 10 are involved in the development of the so-called
11 multiple infarct dementias?

12 A Primary disease has to do with
13 cerebrovascular disease.

14 Q And is this a disease that's influenced by
04:23:14 15 or caused by atherosclerosis?

16 A Yes.

17 Q Do you also see dementias associated
18 with - or dementias in patients who have COPD?

19 A Not as a primary cause, no.

04:23:38 20 Q But ---

21 A They might have other diseases, but the
22 COPD itself is not considered a cause of dementia.

23 Q The COPD could influence the development
24 of dementia in terms of hypoperfusion of the brain?

04:24:02 25 A That would be a very uncommon unusual

51710 6032

04:24:04 1 situation.

2 Q So, most of it, in your experience, is
3 related to atherosclerotic changes?

4 A Most of what?

04:24:14 5 Q Of vascular type of dementias.

6 A Most vascular dementias are related to
7 cerebrovascular problems.

8 Q Is smoking a risk factor in the
9 development of multiple infarct dementia?

04:24:36 10 A Yes.

11 Q Do you know what percentage of patients
12 with dementia are caused by multiple infarct
13 disease?

14 A It's variously reported from 15 to 20, 25
04:24:54 15 percent.

16 Q Another term I've heard used is "MIX" with
17 reference to patients who have both a clinical
18 diagnosis of Alzheimer's, as well as a vascular
19 component to their dementia. Is that a condition
04:25:18 20 that you are familiar with?

21 A I'm not familiar with it being called MIX;
22 but, yes, of course, there are patients that have
23 more than one disease.

24 Q And, so, a patient who has cognitive
04:25:36 25 impairment, this cognitive impairment doesn't --

51710 6033

04:25:38 1 Strike that.

2 A patient who has Alzheimer's disease may
3 have cognitive impairment based on the Alzheimer's
4 disease, but may also have other diseases that
04:25:52 5 influences the level of the cognitive impairment?

6 A That's possible. That would be a minority
7 of the patients who are diagnosed as having
8 Alzheimer's disease.

9 Q You speak in the next paragraph about
04:26:12 10 Alzheimer's disease and Parkinson's disease as being
11 two examples of neurodegenerative disorders commonly
12 seen in Alzheimer's patients; is that correct?

13 A You misspoke yourself. You said in
14 "Alzheimer's disease."

04:26:22 15 Q I'm sorry.

16 A And it's seen in the elderly population.

17 Q I stand corrected. And you state later
18 that 50 percent of the patients in nursing homes
19 suffer from Alzheimer's disease; is that correct?

04:26:38 20 A Yes.

21 Q Is this based on your experience in the
22 nursing home population?

23 A Yes.

24 Q Is Alzheimer's a disease that can be
04:26:50 25 diagnosed by clinical findings?

51710 6034

04:26:54 1 A It's -- That's how the diagnosis is
2 usually made on the basis of clinical findings
3 primarily from historical information and
4 examination of the patient.

04:27:06 5 Q Isn't it true that the conformation of the
6 diagnosis can only be made by histopathological
7 studies?

8 A That's true, but that's a different
9 question.

04:27:14 10 Q So, the diagnosis of Alzheimer's disease
11 is a presumptive diagnosis based on clinical
12 findings?

13 A That's correct.

14 Q Is it your experience in your treatment of
04:27:30 15 geriatric patients and the patients you see in
16 nursing homes that all of the patients who are
17 admitted with Alzheimer's are correctly diagnosed?

18 A No. I think that it's not always an easy
19 diagnosis to make.

04:27:50 20 Q And, again, some of the other patients are
21 patients who have other underlying diseases that
22 mimic some of the symptomology?

23 A It works in worth directions, however. I
24 think that sometimes people who may have been
04:28:08 25 diagnosed as having senility due to cerebrovascular

51710 6035

04:28:10 1 disease, that some of those may also have
2 Alzheimer's disease.

3 So, I think that misdiagnosis is made in
4 both directions.

04:28:20 5 Q Is Parkinson's disease - the dementia
6 associated with Parkinson's disease a large
7 proportion of patients in nursing homes that have
8 dementia?

9 A I'm not sure I understand the question.
04:28:32 10 The question is: Of the patients in a nursing home
11 that have dementia, is Parkinson's - does that
12 constitute a large percentage?

13 Q Yes.

14 A The answer is no.

04:28:44 15 Q Do you know what percentage it is?

16 A Probably less than 10 percent.

17 Q Again, in the next paragraph, Doctor, you
18 talk about the pathogenetic processes involved in
19 the development of - specifically of Alzheimer's and
04:29:04 20 Parkinson's disease; and you talk about risk factors
21 involved in the development of the disease.

22 There are a number of known risk factors
23 that may be associated with Alzheimer's development;
24 is that correct?

04:29:20 25 A There's been a lot of research in that

51710 6036

04:29:22 1 area and a lot of controversy about what may or may
2 not constitute a risk factor, yes.

3 Q And earlier when we talked about -- What I
4 would like to expand on is that there is a familial
04:29:36 5 or possible genetic link to the development of
6 Alzheimer's in certain families; is that correct?

7 A Yes.

8 Q You state in this same paragraph that
9 there's no scientific evidence to conclude that
04:30:02 10 cigarette smoking causes Alzheimer's disease; is
11 that correct?

12 A Yes.

13 Q Are there any studies that show that
14 smoking is not a risk factor or linked to the
04:30:10 15 development of Alzheimer's disease?

16 A I have seen studies where the incidence of
17 Alzheimer's disease was negative related to the
18 consumption of cigarettes.

19 Q In studies that look specifically to
04:30:30 20 Alzheimer's patients who have no familial
21 association - in other words, no family members who
22 have Alzheimer's disease; is that true?

23 A I'm not sure.

24 Q You have stated in this paragraph that, in
04:31:02 25 fact, various studies have shown a negative

51710 6037

04:31:04 1 association between cigarette smoking and
2 Alzheimer's disease suggesting that smoking has a
3 protective effect on Alzheimer's disease.

4 What studies are those, Doctor?

04:31:14 5 A It's a study that I read. I can't tell
6 you the exact - I can't cite the reference right
7 now.

8 Q Was that study a study or paper that you
9 based your opinion on - or based your formation of
04:31:24 10 this opinion?

11 A No.

12 Q Why is that, Doctor?

13 A Because I was aware of that as a fact
14 prior to having read that.

04:31:38 15 Q If the literature looking at smoking as a
16 negative risk factor or as a positive risk factor
17 showed that the negative influence of smoking is
18 only seen in familial type of Alzheimer's disease,
19 would that surprise you?

04:32:00 20 A I just - I don't know the answer in terms
21 of what the facts are; so, I can't really address
22 that.

23 Q Let me restate it then. If there are
24 studies that show that - and a significant number of
04:32:12 25 studies that show that the negative influence of

51710 6038

04:32:14 1 smoking that has been reported earlier, I think in
2 the early Eighties, with regard to the progression
3 or onset of Alzheimer's disease, that's only found
4 in patients who have a familial type of Alzheimer's
04:32:28 5 disease, would that surprise you?

6 A I don't guess I would use the word
7 "surprise." I think that would be of interest.

8 MR. THORPE: Can we go off the
9 record for a minute?

04:32:40 10 THE VIDEOGRAPHER: We are going
11 off the record at 32 minutes after
12 4:00 o'clock.

13
14 (A BRIEF RECESS WAS TAKEN.)

15
16 THE VIDEOGRAPHER: It's 33
17 minutes after 4:00 o'clock. We are
18 back on the record.

19
20 (By Mr. Thorpe)

21 Q Rather than getting bogged down in some
22 scientific studies, I would like to move on since we
23 are time constrained a little bit.

24 And at some point I believe that we will
04:34:28 25 probably ask you and present some of this literature

51710 6039

04:34:32 1 that supports what my contention and the contention
2 of others, but we will leave that for a different
3 time.

4 A Fine.

04:34:42 5 Q Doctor, even though some studies suggest
6 that there is a protective effect of smoking, would
7 you advocate -- Strike that.

8 Even though there are studies that suggest
9 that there may be a protective effect in the
04:35:00 10 development of both Alzheimer's and Parkinson's
11 disease, would you advocate having your patients
12 smoke as a possible method of prevention of the
13 development of these diseases?

14 A No.

04:35:24 15 Q Dr. Stiles, I'd like to turn to the next
16 category of your opinions; and that's entitled "Risk
17 Factors and Reasons for Nursing Home Admissions."

18 You state that in the opening of the first
19 paragraph that the primary risk factor for nursing
04:35:44 20 home placement is age; is that correct?

21 A That's correct.

22 Q Isn't it true that the primary reason for
23 nursing home placement would be the disease state of
24 that patient irrespective of just age?

04:35:56 25 A No.

51710 6040

04:36:00 1 Q Then could you tell us what you base this
2 conclusion on?

3 A The basis for that is, for example, if you
4 look at the people who are in nursing homes, the
04:36:16 5 overwhelming majority of them are elderly people;
6 and that is in most studies that have looked at the
7 factors that are involved in residents being placed
8 in a nursing home. Age is No. 1.

9 Q Is age a criteria for the admission of
04:36:34 10 Medicaid patients?

11 A I believe we discussed earlier that I'm
12 not certain exactly how Medicaid makes the decision
13 about that. My feeling is that the answer to that
14 is probably no. And age is a factor in the
04:36:52 15 development of the functional capacities; so, age is
16 directly related to how they function.

17 Q Have you ever admitted a patient solely on
18 the criteria of their age?

19 A I'm sure I have not.

04:37:08 20 Q You also state that patients are admitted
21 to nursing homes predominantly because of biological
22 and functional - biological functional impairment or
23 behavioral impairment. What do you mean by
24 "biological functional impairment"?

04:37:20 25 A I think that is explained in the next

51710 6041

04:37:20 1 sentence. "Functional impairment includes the
2 impaired ability to perform activities of daily
3 living such as ambulation, bowel and bladder
4 control, bathing, eating and the like."

04:37:32 5 Q Does this also include - or do you include
6 in your biological functional impairment inability
7 to breath on their on without either oxygen or
8 assisted breathing?

9 A Well, I would have to think about that. I
04:37:56 10 have had so few patients where that was the reason
11 for admission to a nursing home. Certainly if
12 someone is requiring assisted breathing, they may
13 well require a nursing home placement. So, yes, I
14 would say that could be included in this list; but
04:38:34 15 the frequency with which that is - what I'm talking
16 about would be extraordinarily small. What I'm
17 talking about here are the main factors that are
18 found in the nursing home population, and the
19 majority of people in nursing home populations have
04:38:52 20 trouble with difficulties that I have listed.

21 The isolated case that you have suggested
22 must be extraordinarily unusual.

23 Q In your discussions as one the
24 impairments, ambulation, is there a cardiovascular
04:39:04 25 component to the inability of patients - their

51710 6042

04:39:06 1 ability to walk?

2 A A cardiovascular?

3 Q Can cardiovascular disease influence the

4 patient's inability to ambulate?

04:39:20 5 A Yes, that's possible.

6 Q Peripheral vascular disease?

7 A That's possible.

8 Q Isn't that, in fact, two influences that

9 do - or two things that do influence the ability of

04:39:40 10 a patient to be able to perform activities of daily

11 living?

12 A It is possible, yes. There are others

13 that would be much more common; but, yes, those are

14 possible.

04:39:52 15 Q What causes bowel and bladder control

16 problems?

17 A Usually it's not known. They are just

18 incontinent. There might be a variety of reasons,

19 but it usually has to do with the nervous system.

04:40:06 20 Q Does it also have to do with

21 atherosclerotic problems?

22 A It can have to do with the vascular

23 supply. Yes, it can.

24 Q Can you define what you mean by

04:40:16 25 "activities of daily living"?

51710 6043

04:40:20 1 A This is variously defined; but it
2 basically has to do with what we would consider
3 ordinary functions such as being able to ambulate
4 unassisted, to go to the bathroom unassisted, to eat
04:40:42 5 unassisted, to care for yourself, to comb your hair
6 unassisted, whether you are continent or incontinent
7 bladder and/or bowel. Those are the types of
8 activities that are ordinarily associated with
9 active daily living, the things that you and I do
04:40:58 10 without giving it much thought.

11 Q A patient in a nursing home, do their
12 underlying disease states have anything to do with
13 their inability to perform activities of daily
14 living?

04:41:10 15 A Yes.

16 Q You also state that one of the criteria
17 for reasons for nursing home placement are
18 behavioral impairments. Does this also include the
19 dementias that we have discussed earlier?

04:41:30 20 A It's really a little different in terms of
21 what I'm trying to point out in this sentence.
22 Certainly people who have dementias have some of
23 these things that I listed here - memory loss,
24 impaired judgment. But there are also patients that
04:41:50 25 don't really meet the criteria of a dementia

51710 6044

04:41:54 1 diagnosis, but have behavior problems. They don't
2 want to eat or they don't want to get dressed or
3 they want to get undressed or they are aggressive or
4 they are agitated or they wander.

04:42:06 5 And they may do these things and not
6 necessarily meet the criteria of a formal diagnosis
7 of a dementia. It's just that their behavior is
8 such that they cannot be managed at home.

9 Q Do these behavioral impairments -- Strike
04:42:18 10 that.

11 Again, the patient's underlying disease
12 state, does that have an influence on some of the
13 behavioral impairments?

14 A It can.

04:42:34 15 Q Have you ever admitted a patient to a
16 nursing home based solely on behavioral impairments?

17 A I'm sure I have not. You meant by that as
18 a diagnosis?

19 Q Yes.

04:42:52 20 A Yes, the answer is no.

21 Q Do you know whether that's a criteria for
22 admission?

23 A I'm sure it's not.

24 Q Under Medicaid?

04:43:02 25 A I'm fairly certain it's not.

51710 6045

04:43:06 1 Q You state that approximately 90 percent of
2 residents in the nursing home have some form of
3 behavioral impairment. Does that - is that -- In
4 that same patient population, do they also have some
04:43:22 5 type of underlying disease state?

6 A I think probably everyone in the nursing
7 homes has some underlying disease state. It may or
8 may not -- Their primary diagnosis may or may not be
9 really contributing to their behavior problems.
04:43:48 10 They may be in there with the primary diagnosis of
11 cancer, but they may also have behavioral problems.

12 Q And the care and treatment they receive
13 are for both the underlying disease state, as well
14 as the other manifestations that they present with;
04:44:00 15 is that correct?

16 A All of the above have to be cared for,
17 yes.

18 Q And Medicaid reimbursement is for all
19 aspects of the patient's - both the patient's
04:44:22 20 condition - both behavioral, as well as biological?

21 A I can't really testify exactly how
22 Medicaid decides to make their reimbursements. I'm
23 not really knowledgeable about that.

24 Q You state next that these functional
04:44:44 25 behavior impairments will lead to most residents

51710 6046

04:44:48 1 seeking nursing home care rather than any one
2 specific disease.

3 Could you explain what you mean by that,
4 Doctor?

04:44:54 5 A Yes. I'm not sure I can make it any
6 clearer than that, but I will try.

7 Normally a patient may have any number of
8 diseases, but it may be that the real reason the
9 family elects to put them in a nursing home is
04:45:16 10 primarily related to their behavior as opposed to
11 specifically any one of those diagnoses. It may
12 just be the behavior problems that they can no
13 longer manage.

14 Q These patients -- Under the Medicaid rules
04:45:28 15 these patients have to have some type of underlying
16 biological disease in order to be admitted; is that
17 correct?

18 A Yes.

19 Q You state next that the diagnosis
04:45:40 20 contained on the nursing home admission form may
21 have nothing to do with the true reason for
22 admission.

23 What do you mean by that, Doctor?

24 A I mean pretty much what I have said - that
04:45:56 25 they may have several conditions in their true

51710 6047

04:46:00 1 diagnoses; but it may not be the real problem that
2 the family is having in terms of managing that
3 resident at home. It may be the behavior problem
4 that is the real problem, and it may have only
04:46:12 5 tangential relation to the - may perhaps even
6 several diagnoses that they have. It's the behavior
7 that's the problem or their inability to perform
8 certain activities of daily living.

9 Q Are you saying in this statement that
04:46:34 10 physicians admit patients to nursing homes not based
11 on their disease?

12 A No, I'm not saying that. I'm saying that
13 the individual may well have all of the diseases. I
14 mean, they will have all the diseases that are
04:46:52 15 listed; but that the actual reason for the family to
16 make the decision that that person needs to be
17 hospitalized may have only tangential relationship
18 to those primary diseases. It may be that it's just
19 that they wander, for example.

04:47:10 20 Q But this isn't the reason that these
21 patients are placed in nursing homes under Medicaid;
22 is that correct?

23 A It may be in the family's mind why they
24 are placed there.

04:47:22 25 Q But without an underlying disease, those

51710 6048

04:47:26 1 patients cannot be admitted under Medicaid, right?

2 A That is correct. So, they have the other

3 diseases, as well.

4 Q And these other diseases contribute to the

04:47:34 5 chronic debilitation of these patients; is that

6 correct?

7 A They may to some extent.

8 Q What do you mean, Doctor, by the next

9 statement: "Many physicians customarily included

04:47:56 10 all known current and past diagnoses of a given

11 resident on the resident's chart, regardless of any

12 actual need to provide medical treatment in the

13 nursing home for the recorded diagnoses"?

14 A What is it about that that is not

04:48:08 15 self-explanatory?

16 Q That to me sounds like that these doctors

17 that you are discussing, or that you are referring

18 to here are admitting patients based not on a

19 medical criteria, but on other criteria.

04:48:28 20 A I'm not sure that I understand your

21 point. The -- Again, the individual may have 15 or

22 20 diagnoses, some of which may be recognized as

23 criteria for being admitted to the nursing home.

24 But the real problem may not be related to those

04:48:50 25 diagnoses. It may be related to the problems of

51710 6049

04:48:54 1 active daily living and just management at home.

2 Q You're not implying that the doctors are
3 admitting these patients fraudulently?

4 A Absolutely not.

04:49:06 5 Q The next statement you make is that:

6 "Nursing home administrative issues often influence
7 what diagnoses are written on nursing home admission
8 forms."

9 What do you mean by that?

04:49:22 10 A The administration is obviously interested
11 in being certain that the resident that is admitted
12 has a diagnosis that is recognized as reimbursable
13 by whatever - whether it's the insurance company,
14 Medicare, Medicaid, whoever it is. So, they are
04:49:42 15 very concerned that that be illustrated on the
16 documents that are going to be necessary to support
17 the reimbursement request.

18 Now, that's not to say that they don't
19 have those diagnoses. It's just that they want to
04:49:54 20 make darn sure that they get listed.

21 Q And you are not implying that they are
22 fraudulently listing something just for
23 reimbursement sake?

24 A Absolutely not.

04:50:10 25 Q Doctor, in the last paragraph on this page

51710 6050

04:50:14 1 you state that: "It's not surprising that a few
2 studies" - "that the few studies that have looked at
3 smoking as a risk factor have found no significant
4 association between smoking and nursing home
04:50:26 5 admissions."

6 Are you saying, Doctor, that the patients
7 who are admitted for cardiovascular diseases, for
8 COPD, for lung cancer, for the various diseases that
9 we have discussed earlier, that smoking is not a
04:50:42 10 risk factor and not one of the reasons that they
11 have developed this disease and they are admitted?

12 A I'm saying that, as we have said several
13 times, the things that you have listed are
14 recognized as risk factors for the development of a
04:50:58 15 variety of diseases as we have discussed. But if
16 you look at smokers and nonsmokers and see whether
17 there is a difference in admission rate to nursing
18 homes, there isn't.

19 Q If you look at the studies that have been
04:51:12 20 done - the epidemiologic studies that have been done
21 with regard to smoking related diseases, that there
22 is no association with regard to nursing home
23 population?

24 A I don't understand the question.

04:51:30 25 Q What studies - what studies are you basing

51710 6051

04:51:30 1 your statement here on?

2 A A, it meets my general understanding of
3 this; and I have read studies that have looked
4 specifically at that question that I have just
04:51:42 5 described - smoking versus nonsmoking admissions to
6 the nursing home. And the smokers are not admitted
7 with any greater frequency.

8 Q When did you read these studies?

9 A I can't answer that question. Sometime.

04:51:54 10 Q What journals did you read these in?

11 A I can't quote it to you.

12 Q Did you do a specific study of this issue
13 with regard to the literature that's available?

14 A Obviously it was an issue that I was
04:52:08 15 interested in as I reviewed articles in preparation
16 for my testimony, yes.

17 Q And you collected these articles; is that
18 correct?

19 A I can't say whether this is an article
04:52:16 20 that I collected or that was supplied to my by the
21 attorneys.

22 Q And you've used these articles and the
23 information in these articles to base your opinion
24 on in this ---

04:52:24 25 A No. I have not.

51710 6052

04:52:26 1 Q Well, you state ---
2 A They were useful and informative.
3 Q You state that there are studies, but you
4 say that you don't - you didn't base your opinion on
04:52:34 5 studies.
6 A That's right.
7 Q And you referenced the few studies that
8 have been looked at, but you haven't provided us
9 with those studies?
04:52:48 10 A That's right.
11 Q Did you do a Med-Line search on this
12 issue?
13 A I did not.
14 Q Did you have one done?
04:53:00 15 A I did not.
16 Q Was one done?
17 A I don't know how TMA got their articles.
18 Q And TMA is where you received these
19 articles?
04:53:12 20 A Yes.
21 Q But you didn't use these articles to base
22 any of your opinion with regard to this statement?
23 A That's right.
24 Q You reference the word "studies," but that
04:53:28 25 wasn't what you based your opinion on?

51710 6053

04:53:30 1 A I believe I have answered that.

2 Q Doctor, you also state in the same

3 paragraph that it's not likely that Medicaid pays

4 more in nursing home costs for smokers than for

04:53:54 5 nonsmokers. What do you base that statement on?

6 A By inference from the topic we have just

7 discussed.

8 Q Did you -- Again, based on the articles

9 that you read?

04:54:08 10 A No. Based on logic.

11 Q So, you are basing your opinion on whether

12 or not Medicaid pays nursing homes more in terms of

13 smoking than nonsmoking just on logic?

14 A Logic and my experience.

04:54:26 15 Q And you stated earlier that you weren't -

16 you have testified earlier that you didn't know how

17 much Medicaid paid with regard to patient care.

18 A I gave you an estimate of the per diem

19 rate.

04:54:40 20 Q But you do not know whether the patients

21 who have smoking-related diseases are reimbursed at

22 a higher rate or a lower rate or cost more during

23 their nursing care; is that correct?

24 A That's correct.

04:54:54 25 Q So, you are making this assumption or this

51710 6054

04:54:56 1 statement based only on your opinion and not on any
2 facts that you have studied or read about; is that
3 correct?

4 A Just my opinion, yes.

04:55:18 5 Q Doctor, in a patient who is in a nursing
6 home, a Medicaid patient specifically who is in a
7 nursing home, and has an underlying disease process
8 and, for example, COPD, who was a smoker and maybe
9 even a current smoker, are you saying that the cost
04:55:46 10 of that patient's care is no greater than a patient
11 who is admitted to the same nursing home for a
12 nonsmoking-related disease?

13 A In that particular patient you don't know
14 whether he - whether his admission had anything to
04:56:00 15 do with the fact that he smoked or not.

16 Q We are talking about cost of care.

17 A Well, whether or not there is any cost
18 incurred depends on whether he is admitted; and in
19 the instance that you have outlined, there is
04:56:16 20 nothing that tells us that he is there because he
21 smoked.

22 Q We do know that in this hypothetical that
23 that patient is there because of COPD and inability
24 to care for themselves in any other type of
04:56:32 25 environment. And in that same hypothetical are you

51710 6055

04:56:36 1 saying that that patient is going to cost the same
2 as a patient who is there for what you call simply
3 behavioral problems?

4 A The cost may vary in terms of what they
04:56:52 5 utilize at the home, yes; but it may or may not be
6 related to smoking. For example, I repeat again,
7 the person that you just described, even though they
8 were a smoker, you don't know that that person is
9 there because they smoked.

04:57:02 10 Q But you are assuming that they are not?

11 A No, I'm not assuming one way or another.
12 I'm just saying that we don't know.

13 Q You are making an assumption that people
14 who are in the nursing home because of
04:57:16 15 smoking-related diseases cost no more than other
16 patients who are nonsmokers.

17 A Well, that statement is taking in an
18 aggregate, not just picking out one patient. The
19 studies that I have reference to are examining
04:57:30 20 patients who are smokers and nonsmokers, not
21 relative to diagnosis, just smokers and nonsmokers.

22 Q And you have not provided us with those
23 studies that you are referring to now?

24 A No.

04:57:56 25 Q Doctor, in a patient - in one of your

51710 6056

04:58:02 1 patients, your experience during your practice, did
2 you find that patients who were smokers who were
3 admitted to the hospital had longer stays than
4 nonsmokers for cardiovascular disease?

04:58:20 5 A All right. I want to make sure I
6 understand the question.

7 The question is: Do smokers who are
8 admitted to the hospital have longer hospital stays
9 than nonsmokers?

04:58:32 10 Q With underlying diseases that are related
11 to smoking.

12 A So, you are -- Are you giving them another
13 disease, or they just have the cardiovascular
14 disease?

04:58:42 15 Q Cardiovascular disease.

16 A I believe that their hospital stays are
17 longer.

18 Q And a patient who is admitted for some
19 type of surgical procedure and that same patient is
04:58:58 20 a current smoker, does that patient have a longer
21 postoperative recovery period than a nonsmoker?

22 A That would be my opinion, yes.

23 Q So, the cost of the hospital care of that
24 patient would be greater in a current smoker than a
04:59:10 25 nonsmoker?

51710 6057

04:59:14 1 A Again, just so that we are clear, you are
2 talking now about hospitalized patients?

3 Q That's correct.

4 A Yes, yes.

04:59:22 5 Q Are patients that are admitted to nursing
6 homes -- Strike that.

7 Patients that are admitted to nursing
8 homes, do they have cardiovascular disease?

9 A There are patients in nursing homes with
04:59:34 10 cardiovascular disease, yes.

11 Q And are some of those patients current
12 smokers?

13 A Yes.

14 Q And you are saying that these patients -
04:59:44 15 the care of these patients is no more than the
16 patients who are nonsmokers who were admitted to the
17 same nursing facility in your experience?

18 A I'm saying that there aren't any more of
19 them, whether they smoked or not.

04:59:58 20 Q I don't understand your answer.

21 A Maybe I didn't understand your question.

22 Q I think the issue we are asking is the
23 incremental costs of patients who are smokers versus
24 nonsmokers, and it's your testimony that these
05:00:18 25 patients incur no greater cost in their care while

05:00:22 1 they are in the nursing home than patients who are
2 nonsmokers?

3 A I'm saying -- That's a little different
4 than what I'm saying. What I'm saying is that if
05:00:32 5 you take a group of elderly smokers and a group of
6 elderly nonsmokers, the frequency with which they
7 get - never mind anything else - just they smoked or
8 they don't smoke and do they get admitted to the
9 nursing home at different rates, it's my opinion
05:00:50 10 that they do not.

11 Q That's not the question.

12 Doctor, you have testified that the
13 incremental cost of a smoker in a hospital is
14 greater than the incremental cost of a nonsmoker
05:01:22 15 admitted for the same reason; is that correct?

16 A That's correct.

17 Q Your earlier testimony.

18 A Yes.

19 Q And so, you are saying now that the
05:01:32 20 incremental cost of a smoker admitted to a nursing
21 home for - as an example, cardiovascular disease -
22 is going to be the same as the incremental cost of
23 that - of a patient with that same type of disease
24 who is a nonsmoker?

05:01:52 25 A Well, I lost you in the last train of

51710 6059

05:01:54 1 thought there.

2 You keep referring to a patient that has
3 chronic lung disease, and I'm keep telling you that
4 I'm not addressing any specific disease here. I'm
5 just talking about elderly smokers and nonsmokers.

6 Q All right. We will make it simple.

7 A Good.

8 Q Is a patient who is a smoker who is
9 admitted to a nursing home any more expensive than a
05:02:26 10 patient admitted to that same nursing home who's a
11 nonsmoker?

12 A If a patient who's a smoker admitted -- I
13 don't know.

14 Q You have stated in your report that it is
05:02:46 15 not likely that Medicaid pays more in nursing
16 homes -- We will move on, Doctor.

17 The next category is: "Nursing Home
18 Population by Payor Sources." And you state that
19 not all nursing home residents are covered by
05:03:06 20 Medicaid.

21 Do you know what percentage of nursing
22 home residents are Medicaid versus other sources of
23 pay?

24 A I think Medicaid patients probably
05:03:24 25 constitute something in the range of 60, 65 percent.

51710 6060

05:03:30 1 Q Doctor, what's the source of your
2 information with regard to the payer ---

3 A My experience and knowledge, and I may
4 have read that somewhere.

05:03:44 5 Q Can you cite any studies that you may have
6 read that in?

7 A No.

8 MR. BORMAN: I will point out
9 that we are a little past our hourly
05:03:56 10 break here. I don't know how much
11 more you want to go. Maybe you just
12 want to finish up in just few
13 minutes.

14 MR. QUINN: Let's leave that up
05:04:02 15 to the witness. If he wants a little
16 short break before we finish ---

17 THE WITNESS: If we can finish
18 by 5:30, let's finish.

19 THE VIDEOGRAPHER: I need to
05:04:12 20 change tapes in about five minutes.

21 MR. THORPE: Do you want to do
22 it now?

23 THE VIDEOGRAPHER: We are going
24 off the record. It's three minutes
05:04:16 25 after 5:00 o'clock. This is the end

05:04:16 1

of Tape No. 2.

2

3

(A BRIEF RECESS WAS TAKEN.)

4

05:11:10 5

THE VIDEOGRAPHER: It's

6

ten minutes after 5:00 o'clock. This

7

is the beginning of Tape No. 3; and

8

we are back on the record.

9

10

(By Mr. Thorpe)

11

Q Doctor, you stated that it's your opinion

12

that 60 to 65 percent of the patients who are in

13

nursing homes are Medicaid patients; is that

14

correct?

05:11:28 15

A Yes.

16

Q And what do you base that information on?

17

A General experience.

18

Q And that's based on six or seven nursing

19

homes where you have had experience in admitting

05:11:46 20

Medicaid patients?

21

A Yes.

22

Q Also, you state that many who were

23

admitted from an acute care setting were paid by

24

Medicare. I think earlier you've testified that the

05:12:00 25

patients who are admitted to nursing homes under

51710 6062

05:12:04 1 Medicare, that's a limited period that they are paid
2 or reimbursed by Medicare; is that correct?

3 A Yes.

4 Q How many days, again?

05:12:10 5 A Again, I'm not absolutely certain. My
6 recollection is that the first period was for
7 30 days and then they are real evaluated and they
8 had perhaps another 30 days. But it was something
9 like that.

05:12:22 10 Q And we also -- I think you testified
11 earlier that after that, there's a co-pay involved?

12 A Yes.

13 Q If the patients are not - if these same
14 patients are not able to meet the co-pay, does
05:12:34 15 Medicaid then begin to cover their admission?

16 A Yes, yes.

17 Q Can you tell us the percentage of Medicare
18 patients that are admitted from an acute care
19 setting are eventually covered by Medicaid?

05:12:52 20 A I don't know.

21 Q In your experience in the patients that
22 you admitted to nursing homes, do you have any
23 opinion with regard to that?

24 A I don't know the numbers. I would think

05:13:06 25 it would be less than 50 percent, but I don't have a

51710 6063

05:13:12 1 number. Most of those are for acute problems which
2 resolve in one way or another.

3 Q And these are based on the admissions that
4 you have made to the nursing homes?

05:13:18 5 A Yes.

6 Q And not some study that you have read?

7 A That's correct.

8 Q You say that a large number of these
9 patients with reference to nursing home residents
05:13:36 10 are self-pay and covered by a program such as the
11 Veteran's Administration. Do you know what
12 percentage of these patients are covered by the
13 V.A.?

14 A I don't have a number based on my
05:13:54 15 experience. It would be a relatively small, but
16 that may have just been my particular location.

17 Q How many of the patients you were involved
18 with and you based your opinion on are - that are
19 nursing home residents are self-pay?

05:14:24 20 A Well, I don't know exactly. Somewhere in
21 the range of 20 percent, but that's a guess. It
22 would be a range around there.

23 Q In that sentence you refer to a large
24 number are self-pay. But in terms of self-pay, per
05:14:46 25 se, you are saying around 20 percent?

51710 6064

05:14:46 1 A Approximately.

2 Q How many of these self-pay patients are

3 covered on short-term stays in the nursing home?

4 A By private insurance - is that your

05:15:00 5 question?

6 Q Yes.

7 A I don't know the answer to that.

8 Q And the same vein of questions - how many

9 of these patients were self-pay are long-term

05:15:12 10 residents?

11 A It would be a fairly - a minority.

12 Q Is the majority of the long-term nursing

13 care - or nursing home residents - are they Medicaid

14 patients?

05:15:30 15 A Yes.

16 Q Dr. Stiles, what have you been told by the

17 defendants in this case with regard to what the

18 State is attempting to recover with regard to

19 Medicaid reimbursements?

05:16:36 20 A Well, I don't know that I have an absolute

21 understanding of that. It's my understanding that

22 the State is attempting to recover Medicaid costs of

23 nursing home patients attributable to smoking.

24 Q Dr. Stiles, do you agree or disagree with

05:17:12 25 that type of lawsuit?

51710 6065

05:17:18 1 A I guess that's not for me to make the
2 judgment.

3 Q We are asking for your opinion and what's
4 your opinion with regard to that type of lawsuit.

05:17:30 5 A People are entitled to make lawsuits about
6 whatever they have - they feel they have an issue.

7 Q That's not the question I've asked.
8 What's your opinion with regard to the basis of this
9 lawsuit?

05:17:42 10 A I think the basis in terms of the part of
11 the lawsuit which I have an understanding and which
12 I have been asked to testify is that the allegations
13 are poorly founded.

14 Q Dr. Stiles, do you believe that the
05:18:14 15 tobacco industry is a good source of health
16 information?

17 A I believe that there have been articles in
18 the news of late that would lead us to believe that
19 they are a source of both good information and
05:18:34 20 perhaps some that has not been as good as others.

21 Q Can you give us an example of what you
22 consider information that was not as good as others?

23 A I have heard news reports relative to
24 information about nicotine and its addictiveness.

05:18:54 25 Q In your experience do you agree or

05:18:56 1 disagree with the statements that have been made
2 about the addictiveness of nicotine?

3 A I'm not an expert in addiction.

4 Q You are a physician who has practiced a
05:19:08 5 number of years and have seen a number of patients
6 who smoke, and you have counseled them to stop
7 smoking. In your opinion based on that experience,
8 do you believe that nicotine is additive or not
9 addictive?

05:19:20 10 A I don't have an opinion because I don't
11 know. I know it's difficult for patients to stop
12 smoking; but why they don't stop, I don't know.

13 Q Doctor, in your experience with patients
14 who have had lung cancer or laryngeal cancer, do you
05:19:46 15 have any experience with those patients who even
16 though they had lung cancer or had had surgical
17 removal of the larynx - in these patients, they
18 still would not quit smoking?

19 A Yes.

05:20:04 20 Q Have you ever had a patient who would
21 smoke through his tracheotomy?

22 A I've heard of such patients. I don't
23 recall that I ever had such patients.

24 Q Doctor, you stated earlier that the
05:20:16 25 litigants in this case have provided you with

51710 6067

05:20:20 1 certain information, with some studies, some
2 documents. Even though you have stated that you
3 have not based your opinion on that, I believe that
4 we are entitled to these documents; and we would ask
05:20:30 5 you not to destroy any of these documents.

6 Would you agree to that?

7 MR. QUINN: Not to destroy
8 them. It's not for you to decide
9 whether we get them. We will work
05:20:40 10 that out with the lawyers.

11 We just want to make sure that
12 you don't throw them away or
13 something.

14 A Yes.

05:20:46 15 MR. THORPE: I think that's all,
16 Doctor. Thank you.

17 Pass the witness.

18 MR. BORMAN: No questions at
19 this time.

05:20:58 20 THE VIDEOGRAPHER: This
21 concludes the deposition. It's 20
22 minutes after 5:00 o'clock.

23

24

25

(WHEREUPON THE DEPOSITION WAS CONCLUDED.)

51710 6068

1 THE STATE OF _____:

2 COUNTY OF _____:

3
4 I, CHARLES STILES, M.D., hereby certify
5 that I have read the foregoing transcript of my
6 testimony given in the foregoing numbered and styled
7 case, and that same is true and correct to the best
8 of my knowledge and belief.

9 I further certify that any and all
10 corrections have been made on a separate page and
11 initialed by me.

12
13 This _____ day of _____, 1997.

14
15
16 _____
CHARLES STILES, M.D.

17
18
19 SWORN TO AND SUBSCRIBED BEFORE ME this

20 _____ day of _____, 1997.

21
22
23 _____
NOTARY PUBLIC

51710 6069

1 THE STATE OF TEXAS:

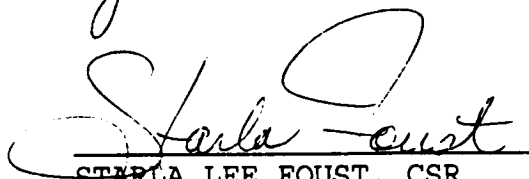
2 COUNTY OF JEFFERSON:

3 I, STARLA FOUST, a Certified Shorthand
4 Reporter, hereby certify that the foregoing
5 testimony was given before me after the Witness had
6 been first duly sworn.

7 I further certify that this deposition was
8 typed under my direction and is a complete and
9 correct transcript of the proceedings; and that it
10 is being filed with the Court in accordance with the
11 Stipulation of Counsel contained in this deposition.

12 I further certify that I am neither
13 attorney for, related to nor employed by any of the
14 parties to the lawsuit in which this deposition was
15 taken. Further, I am neither related to nor
16 employed by any attorney of record in this cause;
17 nor do I have a financial interest in the matter.

18 GIVEN UNDER MY HAND AND SEAL OF OFFICE
19 this 3rd day of August, 1997.

20
21 

22 STARLA LEE FOUST, CSR
23 Certification No. 5946
24 Expiration Date: 12/31/97
25 Charlotte Smith Reporting, Inc.
235 Orleans Street
The Kyle Building
Beaumont, Texas 77701-2399
(409) 839-4407

51710 6070

DEPOSITION STIPULATIONS

NO. 5:96CV91 Deposition of: CHARLES STILES, M.D.

Please complete this Stipulation or state your agreed Stipulations on the record.

The Attorneys for all parties present stipulate and agree to the checked items as follows:

1. Deposition is being videoed. Yes ☒ No ☐

Video Operator: LOU GETZ

2. Deposition is taken pursuant to:

- ☐ a. Texas Rules of Civil Procedure
- ☒ b. Federal Rules of Civil Procedure
- ☒ c. Notice
- ☒ d. Subpoena
- ☐ e. Agreement
- ☐ f. Court Order

3. Objections:

- ☐ a. Reserve all objections, except as to form and responsiveness
- ☐ b. Reserve all objections to time of trial
- ☐ c. Make all objections at the time of deposition
- ☐ d. An objection by one defendant shall be considered an objection by all defendants

4. Signature:

- ☐ a. Signature of Witness is waived
- ☒ b. Witness to read and sign deposition
- ☒ c. If deposition not signed by time of trial, unsigned copy may be used as though signed and timely filed

5. Custodial Attorney:

The deposition original will be sent to MR. LARRY THORPE for safekeeping and use at the time of trial.

6. Foreign jurisdiction:

Reporter may swear the Witness in a foreign jurisdiction. Yes ☐ No ☐

7. Original deposition cost:

Shall be paid by the Attorney asking the first question.

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**LIST OF CASES SINCE 1994 IN WHICH EXPERT HAS TESTIFIED
BY DEPOSITION OR AT TRIAL**

Charles M. Stiles, M.D.

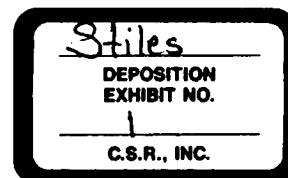
Cause No. 93-09944
Bonnie Wils vs. Beverly Enterprises
Deposition testimony 08/1994.

Cause No. 94-012724
Jessie Crow vs. Methodist Hospital
Deposition testimony 12/1994.

Cause No.
Yolanda Garcia vs. Raymond Garcia
Deposition testimony 11/1994.

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0029283.01



IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
TEXARKANA DIVISION

THE STATE OF TEXAS,

Plaintiff,

v.

THE AMERICAN TOBACCO
COMPANY, et al.,

Defendants.

§
§
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§
§
§
§
§

NO. 5:96CV91

JUDGE DAVID FOLSOM

MAGISTRATE JUDGE
WENDELL C. RADFORD

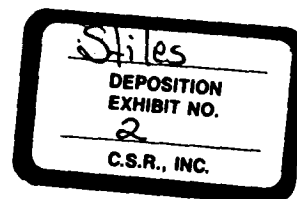
JURY

**SECOND AMENDED NOTICE OF ORAL AND VIDEO
DEPOSITION OF CHARLES STILES ON JULY 29, 1997**

TO: Harold Waldrop, Administrative Liaison Counsel for Defendants
Archley, Russell, Waldrop & Hlavinka, L.L.P.
1710 Moore's Lane
Texarkana, TX 77503

PLEASE TAKE NOTICE that, under Fed. R. Civ. P. 30, Plaintiff, State of Texas, will take the oral and video deposition of Charles Stiles on Tuesday, July 29, 1997, at 1:00 p.m. at Fulbright & Jaworski, 1301 McKinney, Suite 1500, Houston, Texas 77010. Attached hereto is Exhibit A, a subpoena duces tecum, which enumerates documents that the expert shall bring to this deposition. The deposition will continue from day to day until completed.

1. The deposition will be taken before a court reporter appointed or designated under Fed. R. Civ. P. 28. All parties are invited to attend and cross-examine.



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FROM

(MON) 7. 28' 97 17:13/ST. 16:56/NO. 4260825698 P 3

Respectfully submitted,

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GRANT KAISER, BY PERMISSION OF
Walter Umphrey, Attorney-in-Charge

51710 6087

CERTIFICATE OF SERVICE

I hereby certify compliance with Fed. R. Civ. P. 5 and the Case Management Order of November 5, 1996, that a true and correct copy of the foregoing document has been sent by overnight delivery service (with diskette) and facsimile on July 28, 1997, to the following:

Howard Waldrop, Esquire
Atchley, Russell, Waldrop & Hlavinka, L.L.P.
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Texarkana, TX 75505-5517
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EXHIBIT A

As used herein, the term "documents" means any and all tangible things and documents, whether handwritten, typed, printed, or otherwise reproduced, including but not limited to letters, cables, wires, memoranda, and interoffice communications reports, notes, transparencies, minutes; audio, video or recordings; computer printouts, tapes or disks, optical storage, microfilm or microfiche; data compilations of any kind; drawings, sketches, charts, exhibits, photographs and movies; assignments, contracts, agreements and other official documents and legal instruments; published material of any kind; engineering or scientific notebooks and data; travel reports and vouchers; and ledgers, bills, records, invoices, checks, receipts and files. You are commanded by this subpoena to produce all documents in your possession, custody or control that are described below:

Your entire file concerning this case and your work on this case including but not limited to the following:

- a. any and all documents relating to any fee, retainer or engagement agreement you have with Defendants or Defendants' counsel;
- b. any and all documents which you have received from Defendants, Defendants' counsel or any employee, agent or representative of Defendants in this case;
- c. any and all documents which form the basis, or which you considered in forming the basis, in whole or in part, for any opinions you may render in this case or upon which you may rely in rendering any opinions in this case;
- d. any and all documents you have reviewed in preparation for this deposition, whether or not said documents form the basis of any opinions you may render in this case;
- e. copies of any and all documents which you have provided to or which evidence or reflect any communication between you and Defendants, Defendants' counsel, or any agent, employee, or representative of Defendants' counsel in this case;
- f. any and all documents which you have provided to or which evidence or reflect any communication between you and any consultants, non-testifying experts, and any witness in this case, including any other witnesses offered by Defendants or Defendants' counsel, or any representative of Defendants' counsel, as experts;
- g. any and all notes, memoranda, reports, correspondence, summaries, opinions and similar documents which evidence or reflect your factual observations, mental impressions and/or expert opinions in this case;

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- h. copies of any and all drafts or any memoranda, reports, correspondence summaries, opinions, and similar documents which evidence or reflect your factual observations, mental impressions and/or expert opinions in this case;
- i. copies of any and all medical or scientific books, treatises, articles, abstracts, studies, reports, publications or materials which form the basis, in whole or in part, for any opinions you may render in this case or upon which you may rely in rendering any opinions in this case, or alternatively, provide a typewritten list of all such documents indicating sections, segments, or portions that you rely on for your opinions in this case; and

copies of any and all medical or scientific books, treatises, articles, abstracts, studies, reports, publications, or materials in your custody, control or possession that discuss or refer to tobacco related illnesses.

- j. copies of the results of any "Medline", "Toxline", Hazardous Substances Databank, or similar search or computer assisted search for medical, scientific or regulatory articles, books, abstracts or literature which you have performed or reviewed in relation to your work or opinions in this case.
- k. Any and all timesheets, statements, ledger entries, records or similar financial or accounting documents which evidence or reflect the amount of time and expenses you (and any other persons or entities with whom you are affiliated) have incurred in relation to your work in this case. (Alternatively, provide a typewritten statement of your time, by day and date and tasks performed for each listed day, and expenses to date in this case.)
- l. Any video or audio tape recordings of any and all meetings or other preparation sessions you have had with Defendants or Defendants' counsel (or any representative thereof) prior to the date of this deposition.
- m. Any and all invoices, bills, receipts, statements, ledgers, records or similar financial or accounting documents which evidence or reflect any payment or monies owing to you or any payments made to you (and any other persons or entities with whom you are affiliated) by or on behalf of Defendants or Defendants' counsel in this case. (Alternatively, provide a typewritten statement of payments made to you, dates of such payments, and the amounts owing to you or your affiliates by Defendants, Defendants' counsel or any representative of Defendants' counsel.)
- nn. Copies of transcripts of any and all depositions, hearings (including regulatory hearings), and/or trial testimony you have given on behalf of any party.
- o. The most complete and accurate list in your possession of all of your deposition or trial testimony.

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CHARLES M. STILES, M.D.

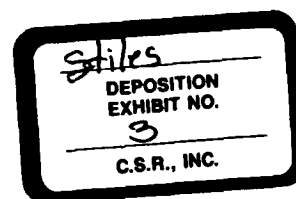
Dr. Stiles' testimony will focus on the multiple medical, behavioral and social factors that contribute to nursing home admissions in the elderly population. He will testify about cognitive impairments in the elderly population and other reasons why elderly patients are admitted to long term institutional care.

Dr. Stiles is expected to testify that the reasons for nursing home admissions differ from acute care hospital admissions, and that diagnoses contained on nursing home admission forms often do not reflect the true reason why elderly patients are admitted to the nursing home. Dr. Stiles will testify about the prevalence of Alzheimer's disease (and other mental conditions) in patients in nursing homes and the lack of association between certain mental conditions and smoking.

In addition to the above, Dr. Stiles may be asked to comment on the opinions expressed by other witnesses and the evidence on which they rely, to the extent these opinions relate to his area of expertise. If individual patient records of medicaid recipients are produced, Dr. Stiles may testify about his review, if any, of these patient records.

Dr. Stiles is board certified in internal medicine and geriatric medicine with over 30 years of experience. He will rely on (1) his skill, education, training and experience as a medical doctor, including his training and experience in internal medicine and geriatrics; (2) his experience in treating patients who enter or reside in nursing homes; (3) his review of medical records, if any are produced, of the individual medicaid recipients designated by the Attorney General; (4) his review of scientific and medical literature on the topics of cognitive impairments in the elderly and nursing home admissions; and (5) his review of information, documents and deposition testimony concerning this case.

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CHARLES M. STILES, M.D.

LIST OF EXPERT OPINIONS

Biologic Mechanisms of Aging

Aging is not a disease but the biological change over time in the function of the various organs and tissues in the body. Aging occurs at various rates among individuals and within an individual at varying rates in different tissues and organs of the body. The biological mechanisms of aging are incompletely understood. Aging may render an individual susceptible to disease.

Certain common disease processes are influenced in their rate of progression by the age of the patient. For example, in certain malignancies such as breast and prostate cancer, it is widely appreciated by clinicians that rate of growth is usually slower, and the frequency of metastasis is less in older people. Prostate cancer, which is often a very malignant disease in younger men, can be a very indolent disease, which may require no treatment in older men.

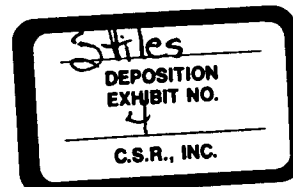
It is also clear that genetic factors are critical in both aging and the predisposition to disease. For example, certain malignant conditions have an inheritable tendency. Also, some dementing illnesses such as Huntington's Chorea are familial. Genetic factors may account for susceptibility to disease and may explain why older individuals exposed to the same environmental factors have an altered rate of appearance of disease.

Cognitive Impairment In the Elderly Population

Cognitive impairment afflicts many elderly patients, and the reasons and associated factors vary. Neurodegenerative diseases, neurologic injury or trauma and genetic factors, to name a few, help provide some explanation for this impairment. A large percentage of those patients admitted to nursing homes suffer from cognitive impairment.

Alzheimer's and Parkinson's disease are two examples of neurodegenerative disorders commonly seen in the elderly population. A significant clinical manifestation in Alzheimer's and in late-stage Parkinson's is cognitive impairment. I estimate that approximately fifty percent of patients in the nursing home suffer from Alzheimer's disease.

Although the pathologic processes involved in the development of these two diseases are not completely understood, multiple risk factors have been identified for both of these disorders. Both age and family history are known to be significant risk factors for the development of both Parkinsonism and Alzheimer's disease. There is no certain nor sufficient scientific evidence to conclude that cigarette smoking causes Alzheimer's disease. In fact, various studies have shown a negative association between cigarette smoking and Alzheimer's disease, suggesting that smoking has a protective effect on Alzheimer's disease. The literature indicates that smokers are less likely



to suffer from Parkinson's disease than nonsmokers, and that smoking has a protective effect on Parkinson's disease.

There are numerous other types of dementia seen both in and out of the nursing home and in the elderly population. While the biological mechanisms involved in the development of dementia are not fully known nor understood, several types of dementia have been found not to be associated with cigarette smoking. In addition to Alzheimer's disease and Parkinson's disease, some of the other dementias not associated with smoking include dementia of metabolic origin, e.g. hypothyroidism and pernicious anemia, dementia from tumor or traumatic injury, dementia from alcohol use or chronic drug use and dementia from depression.

Risk Factors/Reasons for Nursing Home Admissions

The primary risk factor for nursing home placement is age. People are admitted to nursing homes predominately because of biological functional impairment or behavioral impairment. Functional impairment includes the impaired ability to perform activities of daily living such as ambulation, bowel and bladder control, bathing, eating and the like. Behavioral impairment includes such characteristics as memory loss, impaired judgment, and an impaired ability to socialize or interact with others. Approximately ninety percent of residents in the nursing home have some form of behavioral impairment.

It is these functional and behavioral impairments that lead to most residents seeking nursing home care, rather than any one specific disease. In fact, the diagnoses contained on the nursing home admission form may have nothing to do with the true reason for admission. Many physicians customarily include all known current and past diagnoses of a given resident on the resident's chart, regardless of any actual need to provide medical treatment in the nursing home for the recorded diagnoses. In addition, nursing home administrative issues often influence what diagnoses are written on nursing home admission forms.

Several social factors impact the reasons for nursing home admission. A nursing home predominately provides custodial care, and when there is no family member or friend in the home setting or community to assist a person with activities of daily living, the person may be admitted to a nursing home. Inadequate financial resources in the family or home setting may impact a given person's admission to nursing home care.

Given that age and social support are the primary and overwhelming risk factors for admission to nursing homes, it is not surprising that the few studies that have looked at smoking as a risk factor have found no significant association between smoking and nursing home admissions. For the above reasons, it is not likely that Medicaid pays more in nursing home costs for smokers than for non smokers.

Nursing Home Population by Payor Source

Not all nursing home residents are covered by Medicaid. Many who are admitted from an acute care setting are paid by Medicare. A large number are self-pay and some are covered by programs such as the Veterans Administration. These groups have significantly different health profiles and significantly different patterns of utilization.

Dr. Stiles may be asked to comment on the opinions expressed by other witnesses, as well as the evidence on which they rely to the extent that these opinions relate to his areas of expertise. In addition, if individual patient records of Medicaid recipients are produced, Dr. Stiles may testify about his review, if any, of these patient records.